Family Health Network of Central New York, Inc

FAMILY HEALTH NETWORK OF CNY-SCHOOL HEALTH PROGRAM * INSURANCE/DATA FORM

Student name_____ SSN: _____ Date of Birth_____

Address_____ City/Town_____ Zip Code_____

Home Telephone # (_____) _____ Alternate Telephone (e.g. cell) # (_____) _____

Emergency Contact Person _____ Contact's Telephone # (_____) _____

Emergency contact's relationship to student _____

Does student have any allergies? ☐ Yes ☐ No If yes, to what? _____

Allergic reaction (hives, itching, swelling, etc.) _____

Who is the student's designated Primary Care Provider? _____Telephone # (_____) _____

Address _____

This question is strictly confidential and is asked for statistical reporting ONLY:
Student's Race: ☐ White ☐ Black ☐ Asian ☐ Hispanic ☐ Native American ☐ Other_____

INSURANCE INFORMATION – PLEASE COMPLETE BOTH PARTS

PART 1 - IF THE STUDENT HAS MEDICAID, PLEASE COMPLETE THIS SECTION

Identification number from card (i.e.: AB12345C) _____

Does the student have other medical insurance coverage? ☐ YES ☐ NO (If yes, please complete the insurance section below)

INSURANCE INFORMATION – PART 2

Does the student have health insurance coverage? ☐ YES ☐ NO

If yes, name and address of insurance carrier: _____

Insured's ID# _____ Group # _____

Insured's Name (person carrying coverage) _____ Relationship to Student_____

Insured's Date of Birth_____ Insured's Employer _____

Insured's Address (if different from student)_____ City_____ State_____ Zip_____

Complete this section ONLY if there is a Secondary Insurance

Secondary Insurance Information:

Is this student covered by another insurance? ☐ YES ☐ NO If yes, name of insurance _____

Billing address of company_____

Insured's ID# _____ Group # _____

Insured's Name (person carrying coverage) _____ Relationship to Student_____

Insured's Date of Birth_____ Insured's Employer _____

Insured's Address (if different from student)_____ City_____ State_____ Zip_____

Do you have a plan that pays for all or part of prescription medication(s)? ☐ YES ☐ NO

Please complete reverse side

If your child does not have health insurance coverage, he/she may be eligible for **CHILD HEALTH PLUS**. This program is available regardless of income to all children under 19 years of age. This program may be beneficial to your family. Would you like to receive more information regarding this invaluable program? ☐ YES ☐ NO

If your family does not have health insurance, we can provide assistance with enrolling you in health insurance through the Health Exchange. Would you like information on the Health Exchange? ☐ Yes ☐ No

PLEASE READ AND SIGN:
I authorize the release of any medical information necessary to process billing to the designated insurance carrier and made payable to FAMILY HEALTH NETWORK OF CNY, INC.

_____	_____	_____
SIGNATURE	**RELATIONSHIP TO STUDENT**	**DATE**

PLEASE NOTE: If your insurance company remits payment directly to you for services, it is your responsibility to forward this payment to FAMILY HEALTH NETWORK OF CNY, INC., 85 South West Street, Homer, NY 13077. Failure to remit this payment is insurance fraud.