# Campus Health Services Insurance Billing Information

(Front and back copy of the insurance card is required and must be presented before or on the date of service)

**Patient's Name** _____

**NAU ID Number** _____ **DOB** _____

**Patient's Phone Number** _____

**Main Policy Holder's Name** _____

**Main policyholder's Date of Birth (required)** _____

**Main policyholder's Address** _____

**City/State/Zip Code** _____

**Main policyholder's Phone Number** _____

**Relationship to Patient** _____

**I understand that my medical information will be shared with the primary policy holder. The Explanation of Benefits will be sent to the policy holder's address at the time my claim is processed. This document may include my diagnosis and procedure information._____ (initial here)**

- I authorize the release of any medical or other information necessary to process my claim. I authorize payment of medical benefits to NAU Campus Health Services.
- I understand that I am responsible for any copayments, deductibles, or denied charges, which may be posted to my LOUIE account. I understand that I am responsible for verifying my own benefits and that I may be responsible for charges if my plan does not cover services.
- I understand that I will be asked to verify my insurance yearly and will provide CHS updated insurance information if my plan/policy changes throughout the year.
- CHS is contracted with Aetna, Blue Cross Blue Shield, Cigna and United HealthCare. CHS is not contracted with any state plans such as the AHCCCS UHC plan and Medicare. If you are from outside the Arizona network or have an HMO, you are advised to check with your plan to verify out of area benefits.
- If I am a spouse of an employee, I understand payment for copays/deductibles must be paid on the date of service. If I do not pay, I understand that the charges will be directly billed to me personally by CHS.
- I understand that CHS uses a 3rd party laboratory service (Sonora Quest) for certain lab services and that I may receive an additional bill from Sonora Quest.

_____

**Patient's signature** **Date**

☐ I have past charges on my LOUIE account that needs to be billed to my insurance.

**Please note: CHS will only bill for services if we receive your insurance within 5 days of service. If you do not present the card within 5 days, you may be responsible for all charges.

**CHS Use Only:**

Entered: _____ Start Bill Date: _____

Card scanned: _____ Card to be: Faxed or Emailed

Outside special clinic use only: Insurance Carrier _____

Policy ID# _____ Group # _____