Yale HEALTH

P.O. Box 208237
New Haven, CT 06520-8237
203-436-8882
203-432-8254

INSURANCE INFORMATION UPDATE FORM

Please include a copy of your non-Yale Health insurance card

Policy Holders Name: _____ Date of Birth:_____
(please print) (Month / Day / Year)

Address:_____

Telephone Number:_____

If you or your spouse has other health insurance, please complete the following:

Policy Holders Name:_____

Policy Holders Employer:_____

Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Children

Other Insurance Carrier:_____
(including Medicare)

Billing Address:_____

P.O. Box:_____ City, State, Zip:_____

Identification Number:_____ Prescription Drug Rider: ☐ Yes ☐ No

Group Number:_____ Effective Date:_____
(Month / Day / Year)

Family members covered by other insurance

Name	I.D./Group Number	Date of Birth

Authorization

I hereby authorize Yale Health to release information acquired during the course of my examination and release information acquired during the course of my examination and treatment to the Health Care Financing Administration and its agents, or any other third-party carrier as necessary to secure payment of any benefits due to me. I hereby assign payment of said benefits to Yale Health. I agree that this authorization shall be valid until rescinded in writing or replaced by one of a later date.

_____ _____
Signature Date

Revised 8/11