



Insurance Department
Insurance Phone: (407) 823-1649 | Insurance Fax: (407) 823-5723

Insurance Processing Agreement

Between the UCF Student Health Services and (Print Student/Patient Name)

The University of Central Florida Student Health Services Department will provide insurance claim processing for qualified students/patients under the terms listed below:

- 1. THE STUDENT/PATIENT MUST PROVIDE THE FRONT AND BACK OF CURRENT MEDICAL INSURANCE CARDS. Coverage will be verified with the carrier before the claim is filed.
2. Claims will be filed for medical services rendered at the UCF Health Center.
3. We are participating providers with most large insurance companies. Insurance companies in which we are non-participating providers, claims will be processed as out-of-network.
4. For insurance policies that do not have out-of-network benefits, insurance information will be forwarded to outside lab facilities in the event external testing is required.

PATIENT INFORMATION

Name: LAST FIRST MIDDLE INITIAL
Gender: M or F PID#: Birth Date:
Local Phone: Home Phone:

MEDICAL INSURANCE INFORMATION

Medical Insurance Company: Member ID | Policy Number:
Insurance Company Phone Number (found on back of card):

POLICY HOLDER INFORMATION

Policy Holder Name: Policy Holder DOB: Relationship to Patient:
Policy Holders Address:
City: State: Zip Code:

AUTHORIZATION

- I authorize my insurance company to pay to the UCF Student Health Services Department all benefits otherwise payable to me for services rendered.
I authorize the use of this signature on all insurance submissions.
I authorize the UCF Student Health Services Department to release all information necessary to secure the payment of benefits.
I understand that I am financially responsible for all charges whether or not paid by insurance, and that I may be put "on hold" for charges incurred at the Health Center at any time, regardless of pending insurance claims.

PATIENT SIGNATURE: DATE:

IF A MINOR, PARENT/LEGAL GUARDIAN SIGNATURE: DATE:

For Office Use Only:

Verified Through: Policy Effective Date: Plan Type:
Calendar Deductible (Individual): Office Copay: Co-Insurance: Laboratory | X-Ray Coverage: %
Additional Comments:

TIME STAMP INITIALS VERIFIED ON INITIALS