University of Nebraska Medical Center

MUNROE-MEYER INSTITUTE
for Genetics and Rehabilitation

Date: _____ Patient Name: _____

MRN#: _____ Date of Birth: _____

Please fully complete this form to ensure reimbursement from your insurance company

Name of Primary Insurance Company: _____

Claims Mailing Address: _____

_____

_____

_____

Insurance Phone Number: _____

Policy #: _____ Group #: _____ Effective Date of Policy: _____

Name of Insured: _____

DOB: _____ Relationship: _____

Employer Name & Address: _____

_____

_____

_____

Name of Secondary Insurance Company: _____

Claims Mailing Address: _____

_____

_____

_____

Insurance Phone Number: _____

Policy #: _____ Group #: _____ Effective Date of Policy: _____

Name of Insured: _____

DOB: _____ Relationship: _____

Employer Name & Address: _____

_____

_____

Medicare #: _____ Medicaid #: _____

Physicians Assignment: I hereby assign my medical benefits to which I may be entitled to be paid directly to my physician.

Signature: _____ Date: _____

☐ Please check this box if you do not have any insurance coverage

Submit by Email

Print Form

985450 Nebraska Medical Center / Omaha, NE 68198-5450

402-559-6418 / FAX 402-559-5737 / Toll: 800-656-3937 ext 9-6418 / www.unmc.edu/mmi

A University Center for Excellence in Developmental Disabilities Education, Research and Service