Alternate Insurance Form

Please PRINT

Creighton UNIVERSITY Medical Center

Creighton Medical Associates

MRN **Date of Service/Visit #:**

PATIENT INFORMATION

Last Name	First Name	Middle Initial

Date of Birth	Social Security Number

INSURANCE INFORMATION

Injury(ies) due to an accident ❑ At Work ❑ Auto Accident ❑ At Home ❑ Other

Accident City and State *(REQUIRED)*	Date of Injury *(REQUIRED)*

Insurance Co Name *(REQUIRED)*	Claim/Policy # *(REQUIRED)*	Insurance Co Telephone #

Insurance Co Address

Employer Name (if work related)	Employer's Telephone #

Employer Address

Claim Adjustor's Name (if known)	Claim Adjustor's Phone (if known)

COMMENTS/DETAILS

- **Fax completed form and insurance cards to Registration Services at 280-3989**