



University Health Center Medical Insurance Form



In order for us to file your insurance we need the following information on you and the policy holder. If you have a card, please include a **front** and **back** copy. You can mail, fax or email this information to the attention of:

Mildred Huckabee
55 Carlton St.
Athens, GA 30602
706-583-0217 fax
mhuckabee@uhs.uga.edu

Student Information

First name _____ Middle initial _____ Last name _____
Student ID number _____ Date of Birth _____

Insurance Information

Insurance Company _____ Insurance Phone Number _____
Policy or ID number _____ Group _____
Date Coverage began _____
Address _____ City _____ State _____ Zip _____

Primary Policy Holder Information

First name _____ Middle initial _____ Last name _____
Address _____ City _____
State _____ Zip code _____ Date of Birth _____
Phone _____ Place of Employment _____

Relationship to student (circle one): ☐ Self ☐ Spouse ☐ Child ☐ Parent

You have 30 days from the date of service to submit this information. Once you have done this we will remove the flag from your account. After 30 days, we can still file to your insurance but you will have to pay the balance before the flag can be removed.

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