BILLING INFORMATION

MERCYLAND PSYCHIATRY
530 W. Main St., Sun Prairie, WI 53590

Last name: _____ First name: _____ Middle Initial: _____

Date of birth: _____ Phone number: _____

Marital status: _____ Maiden name: _____ SS # _____

Have you ever been here under another last name? _____

Address: _____

Employer: _____ Address: _____ Phone: _____

Emergency contact: _____ Phone: _____

Party responsible for payment if other than patient:

Full name: _____

Relationship to patient: _____

Address: _____

Phone number: _____ Employer: _____

Insurance Information:

Name of insurance: _____

Policy holder's name: _____

SS # of policy holder: _____ Birthdate of policy holder: _____

Is the insurance through a group or employer? _____

Employer name: _____ Address: _____

Pre-authorization: _____

ID number: _____ Group: _____

Medicare: Claim #: _____ Medicaid: ID #: _____

Effective dates: From: _____ Mo. _____ / Day _____ / Yr. _____ To: Mo. _____ / Day _____ / Yr. _____