University of Hawai'i
University Health Services Mānoa
1710 East-West Road | Honolulu, Hawai'i 96822
Phone (808) 956-8965 FAX (808) 956-3583
Secure email via File Drop: www.hawaii.edu/filedrop Recipient: UHSM

HEALTH INSURANCE INFORMATION SHEET

PATIENT INFORMATION

Name: Last	First	Middle	UH ID #
Preferred First Name (if applicable)	Date of Birth (MM/DD/YY)	Sex / Gender	UH Email Address

Local Address	Apt.#	City	State	Zip code	Phone ( )
Permanent Address	Apt.#	City	State	Zip code	Phone ( )

Employer	
Employer Address	Phone ( )

Emergency Contact	Relationship	Phone (Home) ( )	Phone (Work/Cell) ( )

PRIMARY INSURANCE Company: Please attach copy of card (front and back)

Name of Insurance	Policy or ID#	Group #

Subscriber	Subscriber Date of Birth	Subscriber Sex	Plan #

Subscriber Address	City	State	Zip code

Subscriber Phone Number ( )	Effective Date	Expiration Date	Name of Primary Care Provider

Relationship to Subscriber: ☐ self ☐ child ☐ spouse ☐ other, specify: ______________________

For HMSA subscribers only. Choose UHSM to be your primary care provider: ☐ Yes ☐ No

SECONDARY INSURANCE Company: Please attach copy of card (front and back)

Name of Insurance	Policy or ID#	Group #

Subscriber	Phone Number ( )	Subscriber Date of Birth	Subscriber Sex	Plan #

Subscriber Address	City	State	Zip	Effective Date	Expiration Date

Relationship to Subscriber: ☐ self ☐ child ☐ spouse ☐ other, specify: ______________________

INSURANCE CARRIER: I hereby authorize release of information necessary to file a claim with my insurance company and **ASSIGN BENEFITS OTHERWISE PAYABLE TO ME, TO THE UNIVERSITY OF HAWAI'I AT MĀNOA, UNIVERSITY HEALTH SERVICES AS INDICATED ON THE CLAIM**.
I understand I am financially responsible for any balance not covered by my insurance carrier.

Signature of Patient (Parental signature required if under 18) Date

APPOINTMENT REMINDERS VIA TEXT:
I consent to receive text message reminders from **UNIVERSITY HEALTH SERVICES MĀNOA** at the phone number provided, including my wireless number. I understand that I may be charged for such messages by my wireless carrier and that such messages may be generated by an automated messaging system, and that I may opt-out of this service at any time.

Signature of Patient (Parental signature required if under 18) Mobile Number Mobile Carrier Date

Revised 10/06/2021