



MEDICAL CLAIMS SERVICE

PO Box 1265

Redmond, OR 97756

Phone: (541) 504-4676 Fax: (541) 526-1092

PERSONAL INFORMATION FORM

Name of Enrollee: _____ Date: _____

Mailing Address: _____

Phone: _____ Referred By: _____

Birthdate ____/____/____ Social Security No.: _____

Private Home Foster Home Assisted Living Nursing Home

INSURANCE INFORMATION

1. Medicare Number: _____

Medicare Effective Date: Part A: _____ Part B: _____

Part D: _____ Part D Carrier: _____

Part D ID#: _____ Part D Carrier Phone: _____

2. Insurance Co.: _____ Group or Policy No.: _____

Address: _____ Identification No.: _____

Phone: _____

Deductible _____ Prescription Dental Vision

2. Insurance Co.: _____ Group or Policy No.: _____

Address: _____ Identification No.: _____

Phone: _____

Deductible _____ Prescription Dental Vision

Please be sure to include the following:

- Signed Authorization to Release Information forms
- All insurance Explanations of Benefits including Medicare
- All prescription receipts
- All medical billings and statements
- Copies of insurance cards, front and back and current policy, if available