Advocate Physician Partners

PATIENT REGISTRATION
HMO ILLINOIS, BLUE ADVANTAGE HMO, BLUE PRECISION HMO AND BLUE CARE DIRECT HMO MEMBERS ONLY

☐ BroMenn ☐ Lutheran General ☐ Good Shepherd ☐ Sherman
☐ Christ ☐ Illinois Masonic ☐ South Suburban ☐ Silver Cross Health Connection
☐ Condell ☐ Good Samaritan ☐ Trinity ☐ Other _____

☐ New Patient ☐ Existing Patient

PATIENT INFORMATION

(Please Print)

Date_____ **Primary PCP** _____

Patient Name _____

Date of Birth _____ Age _____ Sex ☐ Male ☐ Female

Patient Address _____ Apt Number _____

City _____ State _____ Zip _____

Day Telephone _____ Evening Telephone _____

Patient HMO Member Number _____ Employer Group ID Number _____

HMO Coverage Effective Date _____ **(Attach Copy of Card)** _____

SUBSCRIBER INFORMATION
(Please complete if different than Patient Information)

HMO Coverage Effective Date _____ (Attach Copy of Card)

Subscriber's Name _____ Subscriber's Home Telephone _____

Subscriber's Date of Birth _____ Subscriber's HMO Member Number _____

Subscriber's Address _____ Apt Number _____

City _____ State _____ Zip _____

DEPENDENTS

Name _____ Date of Birth _____ ☐ Male ☐ Female **Primary PCP** _____

Name _____ Date of Birth _____ ☐ Male ☐ Female **Primary PCP** _____

Name _____ Date of Birth _____ ☐ Male ☐ Female **Primary PCP** _____

REQUIRED INFORMATION – OTHER INSURANCE COVERAGE

Is the Patient under any other group insurance plan providing health insurance benefits? ☐ Yes ☐ No

Name of Insurance Company _____ Policy ID Number _____

Policy Holder's Name _____ Group Number _____

Policy Holder's SS# or Medicare Number _____ Policy Holder's Date of Birth _____

Patient's Relationship to Policy Holder ☐ Husband ☐ Wife ☐ Son ☐ Daughter ☐ Other _____

I authorize my physician's billing agent to furnish my health insurance company any information my insurance company may request concerning treatment of myself or my dependents and also request payment of medical insurance benefits to my physician or other medical care providers.

I further understand that if I have any other primary group insurance coverage (which I have not disclosed) that provides health insurance benefits for the services I receive while enrolled with Advocate Physician Partners. I will be held financially responsible for any services reimbursed by any other group insurance coverage.

PATIENT SIGNATURE _____ Date _____

Parent's Signature _____ Date _____
(If Patient is a Minor)

Fax completed copy to: 847-298-9409 or send completed Registration Forms to:
Advocate Physician Partners, Attn: Eligibility, 1701 W. Golf Road, Suite 2-1100, Rolling Meadows, IL 60008

PHYSICIAN OFFICE COPY