CancerCare NORTHWEST™

INSURANCE BENEFITS FORM

Patient Information:

First Name | Middle Name | Last Name | Preferred Name

Mailing Address | Home Address

City | State | Zip | City | State | Zip

Primary Phone: □ Home □ Cell | Alt Phone: □ Home □ Cell | Work Phone | Email Address

Marital Status | Date of Birth | Age | Sex | Social Security Number

Race *(select all that apply)* : □ White □ Black or African American □ American Indian or Alaska Native □ Asian
□ Native Hawaiian or Other Pacific Islander □ Unknown □ Decline to Answer

Ethnicity *(select one)* : □ Not Hispanic or Latino/a □ Hispanic or Latino/a □ Unknown □ Decline to Answer

Language

Occupation | Employer | Employment Status

Emergency Contact | Relationship | Contact Phone: □ Home □ Cell

Referring Physician | Primary Care Physician

Insurance Information:

Primary Insurance Carrier | Insured ID | Policy Group

Insured Person | Insured DOB | Relationship to Insured

Secondary Insurance Carrier | Insured ID | Policy Group

Insured Person | Insured DOB | Relationship to Insured

FOR OFFICE USE ONLY
EPIC BARCODE