

**PRIMARY INSURANCE INFORMATION**

Name of Insurance Carrier: \_\_\_\_\_ Plan Name: \_\_\_\_\_

Name of Insured: \_\_\_\_\_ Patient Relation to Insured: \_\_\_\_\_

Insured's Social Security #: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ Insured's Sex:  Male  Female

Insured's Date of Birth: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ Policy #: \_\_\_\_\_

Group #: \_\_\_\_\_ Group Name: \_\_\_\_\_

Claims Mailing Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Pre-Certification/Authorization Phone #: (\_\_\_\_\_) \_\_\_\_\_ Benefits Phone #: (\_\_\_\_\_) \_\_\_\_\_

**SECONDARY INSURANCE INFORMATION**

Name of Insurance Carrier: \_\_\_\_\_ Plan Name: \_\_\_\_\_

Name of Insured: \_\_\_\_\_ Patient Relation to Insured: \_\_\_\_\_

Insured's Social Security #: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ Insured's Sex:  Male  Female

Insured's Date of Birth: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ Policy #: \_\_\_\_\_

Group #: \_\_\_\_\_ Group Name: \_\_\_\_\_

Claims Mailing Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Pre-Certification/Authorization Phone #: (\_\_\_\_\_) \_\_\_\_\_ Benefits Phone #: (\_\_\_\_\_) \_\_\_\_\_

**(Please notify your insurance company for pre-certification requirements. Failure to pre-certify result in a payment reduction penalty. Please notify your insurance company of your impending admission.)**

**NEWBORN PHYSICIAN INFORMATION**

**\*IT IS VERY IMPORTANT THAT YOU SELECT A DOCTOR FOR YOUR BABY BEFORE YOUR HOSPITAL ADMISSION\***

It is very important to make sure that the pediatrician/family practice physician you choose for your baby has medical staff privileges that permits him/her to practice at your chosen hospital.

Please contact your medical plan/insurance provider representative to ensure your selected pediatrician/family practice physician is currently a member of your chosen hospital medical plan. Thereafter, contact your selected pediatrician/family practice physician before your hospital admission to make sure that he/she is currently accepting new patients.

Be prepared to give the admitting registrar the name of the physician you have selected to care for your baby at the time of admission if there is not one named on this pre-admission form.

Physician's Name: \_\_\_\_\_ Phone #: (\_\_\_\_\_) \_\_\_\_\_

Date you notified this physician: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

\_\_\_\_\_

*Please mail or fax this form immediately to:*

Baptist Medical Center  
111 Dallas Street  
San Antonio, TX 78205  
FAX: (210) 297-0701  
ATTN: Pre-registration

Southeast Baptist Hospital  
4214 East Southcross  
San Antonio, TX 78222  
FAX: (210) 297-0301  
ATTN: Pre-registration

Northeast Baptist Hospital  
8811 Village Drive  
San Antonio, TX 78217  
FAX: (210) 297-0207  
ATTN: Pre-registration

North Central Baptist Hospital  
520 Madison Oak Drive  
San Antonio, TX 78258  
FAX: (210) 297-0401  
ATTN: Pre-registration

St. Luke's Baptist Hospital  
7930 Floyd Curl Drive  
San Antonio, TX 78229  
FAX: (210) 297-0611  
ATTN: WC Pre-registration

*Financial Questions:*

Baptist Medical Center  
(210) 297-7616

Northeast Baptist Hospital  
(210) 297-2621

North Central Baptist Hospital  
(210) 297-4620

St. Luke's Baptist Hospital  
(210) 297-5623

Southeast Baptist Hospital  
(210) 297-3621

*Registration Questions:*

Baptist Medical Center  
(210) 297-7610

Northeast Baptist Hospital  
(210) 297-2626

North Central Baptist Hospital  
(210) 297-4620

St. Luke's Baptist Hospital  
(210) 297-5623

Southeast Baptist Hospital  
(210) 297-3610

**We look forward to the opportunity of serving you and your family**