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

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

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

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

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