



- 1 University of Kentucky Hospital A.B. Chandler Medical Center
- 1 UK HealthCare Good Samaritan Hospital
- 1 UK HealthCare Ambulatory Services
- 1 UK Dental and Oral Health Clinics

UK Pediatric Therapies at Child Development Center of the Bluegrass
-- INSURANCE DEMOGRAPHICS FORM

(Patient Label Here)

Child's Name: _____ Date of Birth: _____

Policy Holder's Name: _____ Date of Birth: _____

Policy Holder Address: _____

Carrier: _____ UKHMO

ID#: _____ Group #: _____

Child's Doctor: _____ Doctor's Office: _____

Parent / Guardian Name: _____

Phone Number: _____ Email: _____

Preferred Method of Contact: Phone Text Email

Are you currently receiving therapy services at another office? Yes No

If yes, what services are you receiving? _____

Services Requested: OT PT SLP

Therapist Requested / Assigned: _____

*******OFFICE USE ONLY*******

Co-pay: _____ # of Visits: _____ Cal / Plan: _____ Combined: _____

Network: In / Out Deductible: _____ Met / Not Met Effective Date: _____

Referral Required: Yes / No At what visit: _____

Authorization #: _____ Expires: _____

Notes: _____

Reference Number: _____