**Memorial**
Health Care Systems

Memorial Hospital • 300 North Columbia Ave. Seward, NE 68434 • Phone 402-643-2971 • Fax 402-646-4639

Dear Parents:

Attached, please find a Student Medical Information Sheet that when completed and returned, will become a valuable resource for our hospital in the event your child needs hospitalization or emergency care.

As a courtesy to our patients, our hospital's business office routinely files claims to insurance companies, however, that is only possible when we know the information requested on this form. If you elect not to participate, please check the appropriate box and sign at the bottom in the designated area.

It is our hope that your child will not need our hospital's services, but in the event of an emergency, the availability of this information will help us to serve you better.

Thank you!

Sincerely,

Melissa Eberspacher

Melissa Eberspacher
Business Office Director

Enclosure: Concordia University Student Medical Information Sheet

**THE INFORMATION PROVIDED ON THE ATTACHED FORM WILL BE USED FOR BILLING PURPOSES ONLY.**

# *Memorial Health Care Systems*
# Seward Memorial Hospital

## CONCORDIA UNIVERSITY STUDENT MEDICAL INFORMATION SHEET

| | |
|---|---|
| Student Name (last, middle, first) | Social Security Number |
| Student Address (address, city, state & zip code) | Student Phone Number |
| Parent's Name (last, middle, first) | Parents Phone Number |
| Parent's Address (address, city, state & zip code) | Student's Date of Birth |
| Insured's Name (last, middle first) | Insured's Social Security Number |
| Insured's Insurance Company | Insured's Policy Number |
| Insurance Company's Address | Insured's Company Phone Number |
| Insured's Employer (name, address, city, state, & zip code) | Employer Phone Number |
| Secondary Insurance (if any) | Insured's Company Phone Number |

Note: We would like to have copies of your insurance cards attached to this sheet. Please be sure to copy both the front and back side of your cards.

| | |
|---|---|
| Parent's Signature | Date |

I wish not to participate in this program ☐

| | |
|---|---|
| Parent's Signature | Date |

**Information on this form will be used by hospital personnel for billing & records purposes only.**