Texas Fertility Center

Insurance Information

Patient Name________________DOB________ Partner Name________________DOB________

Address________________________ Phone #________________________

City/State/Zip________________________ Texas Fertility Center Physician ________________

PRIMARY INSURANCE

Patient's Insurance________________________ Partner's Insurance________________________

ID #________________Group #________ ID #________________Group #________

Address________________________ Address________________________

________________________ ________________________

Phone #________________________ Phone #________________________

SECONDARY INSURANCE

Patient's Insurance________________________ Partner's Insurance________________________

ID #________________Group #________ ID #________________Group #________

Address________________________ Address________________________

________________________ ________________________

Phone #________________________ Phone #________________________

PRESCRIPTION/PHARMACY BENEFITS (Patient Only) IVF/IUI CYCLES

Prescription Plan Name________________________ Rx Group________________________

Rx ID No.________________________ Rx Bin________________________

Employer________________________ Rx Phone________________________

________________________ ________________________ ____________

Patient Name (Printed) Patient Signature Date

________________________ ________________________ ____________

Partner Name (Printed) Partner Signature Date