CHI Health St. Elizabeth

555 So 70th Street, Lincoln, Nebraska 68510, (402) 219-8000

Preadmission Form

PATIENT

Patient: Legal Last Name	First	Middle Initial	Nickname	Previous Admission ☐ Yes ☐ No	Previous Name or Maiden Name

Registration or Expected Due Date	Arrival Time	Sex	Age	Date of Birth	Religion	Baptized ☐ Yes ☐ No

Living Will ☐ Yes ☐ No	Durable Power of Attorney ☐ Yes ☐ No	Marital Status (Please circle) Sin Mar Wid Div Sep	Email Address	Social Security Number - -

Street Address	City/State	Zip	County	Home Phone ( )

Employer Name	City/State	Phone ( )	Occupation

Primary Care Physician	Surgeon/Procedure Physician	Consultant	Newborn Physician

BILLING KIN

Spouse/Parent Name	Address if Different	Home Phone ( )	Work Phone ( )

Name of Emergency Contact (Different Address)	Relationship	City/State	Home Phone ( )	Work Phone ( )

Person Responsible for Health Insurance

Last Name	First	Middle Initial	Address	City/State	Home Phone ( )

Relationship to Patient	Social Security Number - -	Employer	City/State	Work Phone ( )	Occupation

INSURANCE INFO

Accident? ☐ Yes ☐ No	Work Related Injury? ☐ Yes ☐ No	Date	Time	Place

1. Name of Insurance Co.	Policy Number	Group Number	Policy Holder S.S. #

Claim Mailing Address (Ins. Co./Employer/Other)	Policy Holder Name & Relationship	Policy Holder Birthdate

Precertification Required ☐ Yes ☐ No	Authorization Number	Precertification Verification Phone # ( )

2. Name of Other Insurance Co. to bill	Policy Number	Group Number	Policy Holder S.S. #

Claim Mailing Address (Ins. Co./Employer/Other)	Policy Holder Name & Relationship	Policy Holder Birthdate

Precertification Required ☐ Yes ☐ No	Authorization Number	Precertification Verification Phone # ( )

MEDICARE

Medicare Number	Retirement Date	Are you a Veteran? ☐ Yes ☐ No	Did the V.A. refer treatment? ☐ Yes ☐ No	Do you have a "fee basis" I.D. card? ☐ Yes ☐ No

Have you suffered from Black Lung? ☐ Yes ☐ No	Are you entitled to Medicare solely on basis of End Stage Renal Disease? ☐ Yes ☐ No

Spouse employed? ☐ Yes ☐ No	Spouse employer	Spouse retirement date	Date/Place last inpatient hospitalization

Medicaid Plan Name	Complete Medicaid Number (including 2 digit I.D.)	Insurance Policy Number	Group Number

Patient or Guardian Signature ______________________ Date ______________