UMPQUA HEALTH ALLIANCE

Patient Coordination of Benefits Intake Form

Today's Date_____

Patients Name_____ DOB: _____

Patients Employer_____

Spouse Name_____Spouse's Employer_____

Parent(s) Name_____ _____

Parents Employer(s)_____ _____

Please provide a copy of the front and back of your insurance card to front desk staff.

Insurance Company_____

Insurance ID_____

Insurance Company_____

Insurance ID_____

Please fax copy to 541-677-5881 Attn: TPR Department

Or scan and email to: TPR@umpquahealth.com