





DO NOT WRITE IN THE SPACE BELOW

Empty rectangular box for handwritten notes.

<input type="checkbox"/> MEDICARE (Medicare #) <input type="checkbox"/> CHAMPUS (Sponsor's SSN) <input type="checkbox"/> CHAMPVA (VAF #) <input type="checkbox"/> GROUP HEALTH PLAN (SSN or ID) <input type="checkbox"/> FECA (SSN) <input type="checkbox"/> OTHER (ID)		<b>NOT RECORDED BY MEDICAL MUTUAL</b>	
2. PATIENT'S NAME (Last, First, Middle Initial)		3. PATIENT'S BIRTH DATE SEX MM   DD   YY M <input type="checkbox"/> F <input type="checkbox"/>	
5. PATIENT'S ADDRESS CITY STATE		6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>	
ZIP CODE		7. INSURER <input type="checkbox"/> check	
9. OTHER INSURED'S NAME (Last, First, Middle Initial)		8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>	
a. OTHER INSURED'S POLICY OR GROUP NUMBER		Employed <input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time <input type="checkbox"/> Student <input type="checkbox"/> Student <input type="checkbox"/>	
PATIENT'S CONDITION RELATED TO THIS POLICY		ZIP CODE <input type="checkbox"/> YES <input type="checkbox"/> NO	