

University of Iowa Hospitals and Clinics  
PFRS/Registration.  
**DOWNTIME REGISTRATION FORM**

Name: \_\_\_\_\_  
MRN: \_\_\_\_\_ DOB: \_\_\_\_\_  
SSN: \_\_\_\_\_ Sex: M F  
Marital Status: \_\_\_\_\_ Race: \_\_\_\_\_  
Religion: \_\_\_\_\_  
Address: \_\_\_\_\_  
City, St, Zip: \_\_\_\_\_  
Home Tel: \_\_\_\_\_  
Day Tel: \_\_\_\_\_

Patient's Employer

Pat Occ: \_\_\_\_\_  
Employer: \_\_\_\_\_  
Addr L1: \_\_\_\_\_  
City, St, Zip: \_\_\_\_\_  
Emp Tel: \_\_\_\_\_  
Rel to Guar: \_\_\_\_\_

Guarantor 1

Patient's Relationship to Guarantor 1: \_\_\_\_\_  
Guar Name: \_\_\_\_\_  
Guar DOB: \_\_\_\_\_ Guar SSN: \_\_\_\_\_  
Addr L1: \_\_\_\_\_  
City, St, Zip: \_\_\_\_\_  
Guar 1 Occ: \_\_\_\_\_  
Employer: \_\_\_\_\_  
City, St, Zip: \_\_\_\_\_  
Emp Tel: \_\_\_\_\_

Guarantor 2

Patient's Relationship to Guarantor 2: \_\_\_\_\_  
Guar Name: \_\_\_\_\_  
Guar DOB: \_\_\_\_\_ Guar SSN: \_\_\_\_\_  
Addr L1: \_\_\_\_\_  
City, St, Zip: \_\_\_\_\_  
Guar 2 Occ: \_\_\_\_\_  
Employer: \_\_\_\_\_  
City, St, Zip: \_\_\_\_\_  
Emp Tel: \_\_\_\_\_

Emergency Contact 1

Name: \_\_\_\_\_  
Addr: \_\_\_\_\_  
Relationship to Patient: \_\_\_\_\_  
Home Tel: \_\_\_\_\_  
Work Tel: \_\_\_\_\_  
City, St, Zip: \_\_\_\_\_

DATE: \_\_\_\_\_  
STAFF MEMBER: \_\_\_\_\_

Emergency Contact 2

Name: \_\_\_\_\_  
Addr: \_\_\_\_\_  
Relationship to Patient: \_\_\_\_\_  
Home Tel: \_\_\_\_\_  
Work Tel: \_\_\_\_\_  
City, St, Zip: \_\_\_\_\_

Permanent Address

Name: \_\_\_\_\_  
Addr L1: \_\_\_\_\_  
City, St, Zip: \_\_\_\_\_  
Telephone: \_\_\_\_\_

Patient's Identification

Driver License  
Valid License #: \_\_\_\_\_  
State/ Country: \_\_\_\_\_  
Expiration Date: \_\_\_\_\_  
Student ID  
College/ Univ: \_\_\_\_\_  
Student ID #: \_\_\_\_\_  
Enrollment Date: \_\_\_\_\_  
Military ID  
Military Serial: \_\_\_\_\_  
Rank: \_\_\_\_\_  
Expiration Date: \_\_\_\_\_  
Green Card  
Green Card #: \_\_\_\_\_  
Expiration Date: \_\_\_\_\_  
Passport ID  
Passport #: \_\_\_\_\_  
Country: \_\_\_\_\_  
Expiration Date: \_\_\_\_\_  
VISA ID  
VISA Type: \_\_\_\_\_  
VISA #: \_\_\_\_\_  
Country: \_\_\_\_\_  
Expiration Date: \_\_\_\_\_  
I94 Form ID  
Port of Entry: \_\_\_\_\_  
Date of Entry: \_\_\_\_\_  
Alien Number: \_\_\_\_\_

University of Iowa Hospitals and Clinics  
PFRS/Registration.  
**DOWNTIME REGISTRATION FORM**

Insurance Information:

Ins Company: \_\_\_\_\_  
Ins addr: \_\_\_\_\_  
City/State/Zip: \_\_\_\_\_  
FSC & addr: \_\_\_\_\_

Coverage: \_\_\_\_\_  
Policy #: \_\_\_\_\_ Plan #: \_\_\_\_\_ Grp #: \_\_\_\_\_  
Eff from date: \_\_\_\_\_ Eff thru date: \_\_\_\_\_

Auto Ins: Yes  No   
Policyholder name: \_\_\_\_\_  
Policyholder addr: \_\_\_\_\_  
Policyholder SS#: \_\_\_\_\_ 1DOB: \_\_\_\_\_  
Policyholder Sex: M F Rel to PH: \_\_\_\_\_  
Rel to policyholder: \_\_\_\_\_  
Policyholder's group/empl: \_\_\_\_\_  
Empl addr: \_\_\_\_\_  
Empl tel#: \_\_\_\_\_  
FSC to mail to: \_\_\_\_\_  
FSC addr: \_\_\_\_\_

Alt payor name: \_\_\_\_\_  
Alt mailing addr: \_\_\_\_\_

Alt payor tel: \_\_\_\_\_  
Send claims to: \_\_\_\_\_  
Pre-cert phone: \_\_\_\_\_  
Eligibility/Benefits #: \_\_\_\_\_  
Phys co-pay: \_\_\_\_\_  
Specialist co-pay: \_\_\_\_\_  
Inpatient co-pay: \_\_\_\_\_  
ETC/urgent care co-pay: \_\_\_\_\_  
Inpatient mental co-pay: \_\_\_\_\_  
Outpatient mental co-pay: \_\_\_\_\_  
Pharm co-pay: \_\_\_\_\_

MEDICAID

Type of Medicaid: \_\_\_\_\_  
Person #: \_\_\_\_\_  
Case No. \_\_\_\_\_  
Resource \_\_\_\_\_  
County No. \_\_\_\_\_  
Aid Type \_\_\_\_\_  
Coverage Effective Date \_\_\_\_\_  
Referring Phys: \_\_\_\_\_

MEDICARE

Policyholder: \_\_\_\_\_  
Coverage: \_\_\_\_\_  
Medicare No. \_\_\_\_\_  
Name as it appears on card: \_\_\_\_\_  
Effective Date (Part A) \_\_\_\_\_  
Effective Date (Part B) \_\_\_\_\_

DENTAL INSURANCE

Ins Co \_\_\_\_\_  
Insurance Addr \_\_\_\_\_  
City/State/ZIP: \_\_\_\_\_  
FSC: \_\_\_\_\_  
Coverage: \_\_\_\_\_  
Policy No. \_\_\_\_\_  
Emp Name & Addr: \_\_\_\_\_  
PH Name: \_\_\_\_\_  
Addr of Policyholder: \_\_\_\_\_  
Mail claims to: \_\_\_\_\_  
Employer \_\_\_\_\_  
Effective From Date \_\_\_\_\_  
Effective Thru Date \_\_\_\_\_

CHAMPUS

Insur Addr: \_\_\_\_\_  
Coverage: \_\_\_\_\_  
Policy #: \_\_\_\_\_ Grade/Rank: \_\_\_\_\_  
Service Status: \_\_\_\_\_  
Eff From: \_\_\_\_\_ Eff Thru: \_\_\_\_\_  
Policyholder Name: \_\_\_\_\_  
Mail Claim to: \_\_\_\_\_

WORKERS COMPENSATION

Payor name: \_\_\_\_\_  
Addr of Ins Co: \_\_\_\_\_  
City/State/ZIP: \_\_\_\_\_  
Coverage: \_\_\_\_\_  
Policy #: \_\_\_\_\_ Group No.: \_\_\_\_\_  
Emp Name & Addr: \_\_\_\_\_  
City/State/Zip: \_\_\_\_\_  
Policyholder Name & Address: \_\_\_\_\_  
PH SS #: \_\_\_\_\_  
Address of Policyholder: \_\_\_\_\_  
City/State/ZIP: \_\_\_\_\_  
Mail Claims To: \_\_\_\_\_