

CAMP TAKAJO

MEDICAL INSURANCE INFORMATION and PRESCRIPTION COVERAGE

The information below is required by medical providers with whom we have established relationships to ensure the most prompt and professional health care available. In case of accident or sickness, we will submit your insurance information directly to all medical providers. If payment is required at time of service, the camp will pay the provider directly and bill you.

**PLEASE MAKE SURE TO SUBMIT COPIES, FRONT AND BACK,
of your MEDICAL INSURANCE CARD
and your PRESCRIPTION COVERAGE CARD (if applicable).**

(If not applicable, please leave blank.)

1. CAMPER's NAME _____ SEX ____ DOB ____-____-____
2. CAMPER's NAME _____ SEX ____ DOB ____-____-____
3. CAMPER's NAME _____ SEX ____ DOB ____-____-____

MEDICAL INSURANCE:

Insurance Company _____
Customer Service Phone No. _____-_____-_____
Group / Policy Number _____
Type of Plan _____
Member's Name _____
Relationship to Camper _____
Member's ID Number _____
Member's Social Security _____-_____-_____
Member's Date of Birth _____-_____-_____

PRESCRIPTION INSURANCE:

Insurance Company _____
Customer Service Phone No. _____-_____-_____
Group / Policy Number _____
Member's ID Number _____
PCN Number _____
BIN Number _____