



# Grand Valley Health Plan

Welcome to Grand Valley Health Plan! Thank you for choosing us as your healthcare provider. If you have any questions, please do not hesitate to call our Customer Service Department at (616) 949-2410. We're here to help!

## Patient Information

Last Name:		First Name:		Middle Initial:	Previous GVHP Member:	
Birth Date:	Social Security Number:		Sex:		<input type="checkbox"/> Yes <input type="checkbox"/> No	
	-	-	<input type="checkbox"/> Male <input type="checkbox"/> Female			
Home Address:			City:	State:	Zip Code:	Marital Status:
Home Phone: ( )			Alternate Phone: ( )			

## IMPORTANT: Please select one Grand Valley Family Health Center in which you will receive your care.

<input type="checkbox"/> Beckwith (NE Grand Rapids) 224-1515	<input type="checkbox"/> Jenison 457-3830	<input type="checkbox"/> Kentwood 534-8323	<input type="checkbox"/> Rockford 866-9568	<input type="checkbox"/> Walker 784-4717	<input type="checkbox"/> Wyoming 532-1100
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## About You:

I Prefer to be Called:					
Name of Your Previous Doctor:					
Phone Number of Previous Doctor:			Fax Number of Previous Doctor:		
Your Ethnicity (circle all that apply):					
African American	Asian	Caucasian	Hispanic/Latino	Native American	Pacific Islander
Your Preferred Language:					
English	Bosnian	Korean	Spanish	Vietnamese	American Sign Other: _____
My Preferred Method of Communication is (circle one):					
Home Phone		Alternative Phone		E-Mail	

## Emergency Contact Information:

Emergency Contact Name		
Address:		
City:	State	Zip Code
Relationship to You:		
Home Phone: ( )		Alternate Phone: ( )



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## Other Insurance Information-Primary (First Payer)

Name of Subscriber:	Birth Date of Subscriber:	Sex Of Subscriber: <input type="checkbox"/> Male <input type="checkbox"/> Female
Your Relationship to the Subscriber:		
Insurance Carrier:	Original Effective Date of Policy	
Group Name:	Policy Number:	Group Number:
Is there an active Qualified Medical Support Order on file, which dictates this coverage to be primary? <input type="checkbox"/> Yes <input type="checkbox"/> No		

## Other Insurance Information-Secondary (Second Payer)

Name of Subscriber:	Birth Date of Subscriber:	Sex Of Subscriber: <input type="checkbox"/> Male <input type="checkbox"/> Female
Your Relationship to the Subscriber:		
Insurance Carrier:	Original Effective Date of Policy	
Group Name:	Policy Number:	Group Number:
Is there an active Qualified Medical Support Order on file, which dictates this coverage to be primary? <input type="checkbox"/> Yes <input type="checkbox"/> No		

## Other Insurance Information-Medicare

Name of Beneficiary on Medicare card:	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	
Medicare Number: - -	Medicare Part A (Hospital) Effective Date:	Medicare Part B (Medical) Effective Date:
Are you actively working? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, please list employer:	Employer Phone:

Please present any active insurance identification cards with this form. In addition, you may be asked, at the time of service, to present proof of identity or insurance.

In signing this form, I agree to the following:

1. I acknowledge GVHP's right to conduct utilization review programs of health services and to coordinate benefits and or reimbursements with the above-mentioned insurance carriers.
2. I have received and agree to the Office Financial Policy of GVHP

Signature: \_\_\_\_\_ Date \_\_\_\_\_

