# Texas Fertility Center

## Insurance Information

Patient Name______________________DOB________ Partner Name______________________DOB________

Address______________________________________ Phone #______________________________________

City/State/Zip_________________________________ Texas Fertility Center Physician ______________________

### PRIMARY INSURANCE

Patient's Insurance_______________________________ Partner's Insurance_______________________________

ID #_________________________Group #__________ ID #_________________________Group #__________

Address______________________________________ Address______________________________________

______________________________________________ ______________________________________________

Phone #______________________________________ Phone #______________________________________

### SECONDARY INSURANCE

Patient's Insurance_______________________________ Partner's Insurance_______________________________

ID #_________________________Group #__________ ID #_________________________Group #__________

Address______________________________________ Address______________________________________

______________________________________________ ______________________________________________

Phone #______________________________________ Phone #______________________________________

### PRESCRIPTION/PHARMACY BENEFITS (Patient Only) IVF/IUI CYCLES

Prescription Plan Name____________________________ Rx Group______________________________________

Rx ID No.____________________________________ Rx Bin________________________________________

Employer_____________________________________ Rx Phone______________________________________

______________________________ ______________________________ ____________

Patient Name (Printed) Patient Signature Date

______________________________ ______________________________ ____________

Partner Name (Printed) Partner Signature Date