

Name of insurance company: _____

Name of insurance plan: _____

Phone number: _____

Website: _____

My mailing address where I can receive any paperwork or important messages:

IF I DON'T HAVE INSURANCE...

I want to apply...(check one)

☐ With my discharge planner

☐ Over the phone

Phone number to call: _____

☐ Online

Website to visit: _____

☐ In-person

Location and address: _____

While I'm not insured, here are some places I can get health care if I need it (find clinics near you on page 27):

Name of facility _____

Address _____

Phone _____ Hours _____

Name of facility _____

Address _____

Phone _____ Hours _____

Name of facility _____

Address _____

Phone _____ Hours _____