

Basic Demographics

| Name | MRN | SSN | Sex | Date of Birth |
|------------------------|-------------------|----------------|--------|-------------------|
| Horlander, Katie | 04099408 | xxx-xx-1793 | Female | 7/3/2000 (19 yrs) |
| Ethnic Group | Marital Status | Patient Status | | |
| Not Hispanic or Latino | Significant Other | Alive | | |

Contact Information

| Address | Phone | E-mail Address |
|--|--|------------------------|
| 358 Redbird Dr LOVELAND OH 45140-9208 | 513-716-7258 (Home) 513-716-7258 (Mobile) *Preferred* | khorlander45@gmail.com |

Additional Info

| Aliases | Preferred Language | Interpreter Needed |
|---|--------------------|--------------------|
| HORLANDER HORLANDER,KATIE HORLANDER,KATIE L | English | No |

PCP and Center

| Primary Care Provider | Center |
|-----------------------|-------------------|
| No Pcp | WCH MAIN HOSPITAL |

Pharmacy Preferences

| Pharmacy |
|--|
| WALGREENS DRUG STORE #07637 - MILFORD, OH - 1243 STATE ROUTE 28 AT SWC OF WOODVILLE & RTE 28 |

Employment Information

| Status | Employer | Occupation |
|-----------|---------------------------|------------|
| Full Time | Hospice of Southwest Ohio | STNA |

Administrative

| Signature on File | Date Filed |
|-------------------|--------------|
| Yes | None on file |
| Power of Attorney | Date Asked |
| No | None on file |
| Advance Directive | Date Asked |
| No | None on file |

Patient Contacts

| Name | Relation | Home | Work | Mobile | Preferred Language |
|--------------------|-------------------|------|------|--------------|------------------------|
| Stewart, Cody | Significant other | | | 513-987-7525 | Interpreter needed? No |
| Horlander, Vernie | Mother | | | 513-546-5540 | |
| Horlander, Charlie | Father | | | 513-386-4620 | |

Active Insurance as of 4/20/2020

| LIABILITY - COMMERICAL LIABILITY | | | |
|----------------------------------|-----------------------|---------------------|---------------------|
| Payor | Plan | Insurance Group | Employer/Plan Group |
| LIABILITY | COMMERICAL LIABILITY | | |
| Coverage Address | Coverage Phone Number | Coverage Fax Number | Effective Dates |

| | | | |
|--------------------------------|-------------------------|-----------------------|-------------------------|
| Coverage Address | Coverage Phone Number | Coverage Fax Number | Effective Dates |
| 3200 Burnet Ave | | | 4/9/2020 - None Entered |
| AVONDALE OH 45229 | | | |
| Subscriber Name | Subscriber Birth Date | Member ID | |
| HORLANDER,KATIE | 7/3/2000 | 300-04-1793 | |
| HUMANA - HUMANA HMO POS | | | |
| Payor | Plan | Insurance Group | Employer/Plan Group |
| HUMANA | HUMANA HMO POS | 863999 | |
| Payor Plan Address | Payor Plan Phone Number | Payor Plan Fax Number | Effective Dates |
| PO BOX 14601 | | | 1/1/2020 - None Entered |
| LEXINGTON KY 40512-4601 | | | |
| Subscriber Name | Subscriber Birth Date | Member ID | |
| HORLANDER,KATIE | 7/3/2000 | 114947633 | |

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