St. John's Military School
PO Box 5020, Salina, Kansas 67402-5020
785.823.7231• Fax 785.309.5489

AUTHORIZATION FOR PAYMENT OF PRESCRIPTION AND MEDICAL SERVICES

Cadet Information

Last Name ______________________ First ______________________ MI ______________

Date of Birth ______________________ Height ______________ Weight ______________

Emergency Contact ______________________________ Phone ______________

Hometown Physician ______________________ Address ______________________________

Responsible Party

Last Name ______________________ First ______________________ MI ______________

Mailing Address ____

City ______________________ State __________ Zip ______________________

Phone Number ______________________ Email Address ______________________________

Work Phone ______________________ SS# ______________________________

Insurance Information

Cardholder Name ____

Employer or Group Name ______________________ Company ______________________

ID Number ______________________ Group Number ______________________

Person Code # ______________________ SS # ______________________

(Please include a copy of the front and back of your prescription card)

Insurance Payment Agreement

The undersigned hereby agrees to the following:

Whereas St. John's Military School uses the services of various health care providers (Service Provider(s));

Whereas the Service Provider(s), at the insured's request & as a courtesy to the insured, have agreed to bill the insured's company for prescribed medication, medical related items, and services prescribed by the insured's physician and accept assignment on the anticipated insurance payment.

I hereby authorize the Service Provider(s) to directly receive payment for all purchases and to give the necessary information to receive such payment.

I also hereby agree that if the insurance company makes payment directly to me, to remit that sum immediately to the Service Provider(s).

I understand that a reasonable effort will be made to notify me prior to any charges being assessed, but notification notwithstanding, I acknowledge final responsibility for the prescription medication, supplies and services provided and agree to pay the deductible amount and any other amounts that the insurance company does not pay the Service Provider(s), and I understand that the Service Provider(s) will bill me for the balance.

Signature of Insured/responsible party ______________________________ Date ______________