



AUBURN UNIVERSITY
AT MONTGOMERY

WARHAWK HEALTH SERVICES

Patient Information UPDATE Form

Are you an AUM Faculty or Staff member? ☒ Yes ☐ No Are you an AUM Student? ☐ Yes ☐ No

If yes, please select the semester you are currently enrolled: ☐ Fall ☐ Spring ☐ Summer

PATIENT INFORMATION (PLEASE PRINT LEGIBLY)

Date: Nov. 1, 2022 Student Number: _____ Birthdate: 12/10/1962
Last Name: Rauccio First Name: Carol Preferred: _____
Phone Number: 334-315-5514 Email: crauccio@aum.edu
Local Mailing Address: 8713 Marsh Ridge Drive Box or APT#: _____
City: Montgomery State: AL Country: _____ Zip Code: 36117
Primary Physician: Dr. Danny Ingram State: _____ Phone Number: 334-365-2205
Emergency Contact: Romain Rauccio Relationship: Son Phone Number: 334-399-2044

INSURANCE INFORMATION

Do you have health insurance? ☒ Yes ☐ No

If yes, please give your card to the front desk in order for a copy to be made for your chart.

Primary Insurance Company: BC BS of Alabama Policy or Contract Number: QAU 870546564
Group number: 37655 Name on Insurance Card: Carol W. Rauccio
Relationship: _____ Policy Holder Date of Birth: 12/10/62
Policy Holder's Employer: AUM Phone Number: _____

MEDICAL HISTORY

Do you have any new allergies or medical conditions?

No

Please list any medications you are currently taking:

Astorvastin 10 mg - 1 daily
Lisinopril 20 mg - 2 daily
Hydrochlorothiazide 25 mg 1 daily
Lansoprazole 30 mg 1 daily
Plexus ProBio5 1 daily

Preferred Pharmacy and Phone Number: Walgreens 6680 Atlanta Highway 36117

PATIENT HIPAA CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment)
- Obtaining payment from third party payers (e. g. my insurance company)
- The day-to-day healthcare operations of your practice

I have also been informed of and given the right to review and secure a copy of your Summary of the HIPAA Privacy Rule, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and health care operations, but that you are not required to agree with these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

General Consent for Treatment

I request and authorize health care services by my provider and his/her designees(s) as my provider may deem advisable and in my best interest. This may include routine diagnostic, laboratory procedures, and administration.

I understand that excluding emergency or extraordinary circumstances, no substantial procedure will be performed without providing me an opportunity to give me informed consent for that procedure. Informed consent means that the medical provider must disclose information to me including benefits and risks of a particular procedure and/or treatment.

Payment

I am responsible for all bills incurred at the Student Health Center. Payment is due at the time that services are rendered unless prior arrangements have been made.

I have read the consent form, or it has been read to me, and I am satisfied that I understand its contents. My questions have been answered to my satisfaction.

Signature: Carol Rauccio Date: 11 / 1 / 22
Print Patient's Name: Carol Rauccio

Relationship to Patient (if you are the patient, write "self"): _____

Warhawk Health Services
Medical Information Release Form (HIPAA Release Form)

Name: Carol Rauccio Date of Birth 12/10/1962

Release of Information

☐ I authorize the release of information including the diagnosis, records, examination rendered to me, and claims information. This information may be released to:

Name: Roman Rauccio Phone: 334-399-2044 Relationship: son
Name: Brooke Rauccio Phone: 334-301-1757 Relationship: daughter-in-law

Name: _____ Phone: _____ Relationship: _____

Name: _____ Phone: _____ Relationship: _____

CR ☒ Information is not to be released to anyone.

This Release of Information will remain in effect until terminated by me in writing.

Messages

Please call ☐ my home ☐ my work ☒ my cell number: (334)-315-5514

If unable to reach me:

☐ Please send me an email ☒ Please leave me a message to return your call
☐ Please leave me a detailed message ☐ Other

The best time to reach me is:

☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday

☐ Morning ☐ Early Afternoon ☐ Late Afternoon ☒ Anytime

Signature: Carol Rauccio

Date: 11/1/2022

November 1, 2022

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Akshay Kumar Reddy Katta
 PO BOX 244023
 Montgomery, AL 36124

Thank you for being a UnitedHealthcare StudentResources member.

We're glad you're here.

This is your UnitedHealthcare health plan ID card. It has information about you and your coverage so you'll want to take it with you wherever you go.

Due to the Consolidated Appropriations Act, your ID card now includes all applicable network and out-of-network deductibles and network and out-of-network out-of-pocket maximums for both individuals and family. Any additional benefits your plan may have, such as telehealth services, will no longer be included on your ID card but can still be found in your My Account.

Please be sure all the information on your ID card is correct. Call us using the toll-free member number on your ID card if any information is not correct or you need assistance. You can start using your ID card on your effective date.

To get the most out of your plan, follow these steps:

1. Get access on the go.

Create your My Account at www.uhcsr.com/myaccount. Our mobile friendly website will help you:

- Find and estimate the cost of the care you need.
- See what's covered and get information about any additional benefits available to you.
- View claim details and account balances and much more.

2. Check out our videos page.

www.UHCSR.com/video has many informative videos on how to access and utilize key elements in your My Account, as well as a large library of mental health videos provided by Psych Hub.

3. Know your network.

With almost every plan, you'll pay less if you choose doctors, clinics and hospitals in your network. Search for network providers on www.uhcsr.com or the UHCSR mobile app.

STD (4/22)

Attached is your new UnitedHealthcare ID card. The ID card contains important phone numbers and claim filing instructions.

 UnitedHealthcare® StudentResources		2022-23 Academic
Insured: Akshay Kumar Reddy Katta SR ID #: 8600893 Policy #: (80840): 2022-38-4 Plan Name: Auburn University		
Members: Customer Service 1-800-767-0700		Providers: Customer Service 1-888-224-4875
Optum Rx® Rx Bin: 610279 Rx PCN: 9999 Rx Group: UHCSTRC01		
DED IND/FAM INN: \$250/ OON: \$500/	OOPM IND/FAM INN: \$7150/\$14300 OON: N/A	
 UnitedHealthcare Choice Plus ID1:22S Underwritten by UnitedHealthcare Insurance Co.		

CLAIMS INSTRUCTIONS	
Submit claims to the company within 90 days or as required by state law after the date of service. Mail all medical bills along with the insured student's name, patient's name, SR ID number, address, and group name to the address listed below:	
Send claims to: StudentResources P.O. Box 809025 Dallas, TX 75380-9025 EDI Payer ID: STDNT for 276-277; 74227 for 837 & 270-271	For emergencies while traveling call: UnitedHealthcare Global 1-877-461-2273 (Toll-free) or 1-410-453-6330 or email: assistance@uhcglobal.com ID#: 355751
For Hospital pre-admission notification call UnitedHealthcare at 1-877-295-0720.	
NOTICE TO ALL HEALTHCARE PROVIDERS	
This card is not a guarantee of coverage. For information concerning coverage, co-payment and claims instructions, please call Customer Service at the number listed on the front of this card	
22-IDI	www.uhcsr.com