

IU Employees - NOT Insured Through an IU Sponsored Medical Plan

Name (please print): _____

Local Address: _____

City, State, Zip: _____

Campus or Cell Phone #: _____ Date of Birth: _____

	<p>The information provided above is to document services provided, not for billing purposes.</p> <p>Employee ID # _____</p> <p>The cost is \$37.00. Payment is due at the time of service – <u>checks only</u> at campus area clinics. All payment methods are accepted at the Health Center.</p> <p>Make checks payable to: IU Health Center.</p>