

**Childbirth Experience Classes Insurance Form**  
**855 Mankato Avenue ~ PO Box 5600**  
**Winona, MN 55987-0600**  
**507.494.7384**

*Healthcare provider notice of possible denial of medical benefits for childbirth classes*

.....

Client (Mom-to-be) Name \_\_\_\_\_ Maiden Name \_\_\_\_\_ DOB \_\_\_\_\_

Spouse's Name \_\_\_\_\_ Address \_\_\_\_\_

City, State \_\_\_\_\_ Zip Code \_\_\_\_\_

Social Security Number \_\_\_\_\_ Phone Number \_\_\_\_\_

Physician/Midwife \_\_\_\_\_ Due Date \_\_\_\_\_

**Insurance Information**

1) Insured Name \_\_\_\_\_ (name of policy holder)

Insurance Company Name \_\_\_\_\_

Address of Insurance Company \_\_\_\_\_

Insured's Social Security Number \_\_\_\_\_ Effective Date \_\_\_\_\_

ID Number \_\_\_\_\_ Group Number \_\_\_\_\_

Family / Single Coverage \_\_\_\_\_

.....

2) Name of Secondary Insurance \_\_\_\_\_ Group Number \_\_\_\_\_

Policy Number \_\_\_\_\_ Name of Policy holder for Secondary \_\_\_\_\_

.....

Childbirth Education Classes Start Date \_\_\_\_\_

Childbirth Education Classes may not be a covered service for some insurance. If my insurance denies payment, I agree to be personally and fully responsible for payment to Winona Health.

\_\_\_\_\_

\_\_\_\_\_

Date

Patient Signature