1900 10th Avenue, Suite 325
Columbus, Gorgia 31901
706.571.1508

Piedmont
COLUMBUS REGIONAL
REGIONAL PERINATAL CENTER

8:00a.m. – 4:30p.m. Monday-Friday

Maternal Benefits Application

Patient Information

Patient: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone #: _____ Birthdate: _____

Total # in family/household (include self, spouse, and children): _____

Married or Single? (Circle One)

Financial Information:

Patient place of employment: _____

Employer's address: _____

Employer's phone #: _____Gross income (monthly or annually): _____

If applicable:

Spouse full name: _____

Spouse's place of employment: _____

Employer's Address: _____

Employer's Phone #: _____Gross income (monthly or annually): _____

I verify that the information I have provided is true and correct. I authorize Piedmont Columbus Regional to furnish information concerning my hospitalization to the Department of Public Health for the annual benefit audit.

_____

Patient Signature *Date*

_____

Spouse Signature *Date*

11439-0324