PRE-BOOK APPLICATION

APPLICANT INFORMATION FORM

Patient Name _____ Date of Birth _____

Home Phone _____ Work Phone _____Cell Phone_____

Address_____

_____

Emergency Contact: _____ Phone _____

MCNR participates with the following insurance companies:

Aetna Us Healthcare Blue Cross/Blue Shield Oxford Cigna Connecticare

Please enclose a copy of your insurance cards.

Primary Insurance Name and ID Number _____

Secondary Insurance Name and ID Number _____

Prescription Insurance Name and ID Number _____

Type of Surgery _____

Date of Surgery _____

Hospital where surgery takes place _____

Primary Physicians's Name _____

Surgeon's Name _____

Height _____ Weight _____

Signature of Applicant _____

Applicant: _____
Last First Middle

Date Received: _____ Time Received: _____

Receipt # _____

PRE-BOOKING ADMISSION APPLICATION

Thank you for your interest in Pre-booking your Rehab stay at Mansfield Center for your post-surgical needs! You have contacted MCNR and indicated a desire to be admitted as a patient to this facility. Because of this, you have been issued a receipt indicating the date and time of your initial request and your name has been placed on our inquiry list.

As soon as you substantially complete and return the Applicant Information Form to Mansfield Center for Nursing and Rehabilitation, your name will be placed on our Pre-Book list for admission to the facility.

PLEASE RETURN TO:

Mansfield Center for Nursing and Rehabilitation
Attention: Dalia Alberdi, Admissions Director
100 Warren Circle
Mansfield, CT 06268-2074

The information presented in this application is correct to the best of my knowledge. I have no objection to inquiries for the purpose of verifying it. I understand that misinformation or failure to report changes in information shall constitute grounds for the rejection of my application.

Signature of Applicant _____

Signature _____

Relationship to Applicant _____