INSURANCE INFORMATION

PRIMARY INSURANCE

Primary Insurance Company Name: _____

Policy Holder's Name: _____

Policy Holder's SSN: _____ **DOB:** _____

Policy Holder's ID# _____

Policy Holder's Group #: _____

Claim Mailing Address: ***Be sure you have the correct address for mental health claims***

_____

Street Address City State ZIP

Insurance Company Mental Health Phone Number: (____)_____

Deductible: $_____ **Has it been met?** _____

Co-payment (amount not covered by your insurance for each visit): $_____

Who will pay noninsured balance? _____

If you are required to get preauthorization, have you done so? _____

Authorization #: _____ **Number of visits authorized:** _____ **Effective dates :** _____

SECONDARY INSURANCE

Secondary Insurance Company Name: _____

Policy Holder's Name: _____

Policy Holder's SSN: _____ **DOB:** _____

Policy Holder's ID# _____

Policy Holder's Group #: _____

Claim Mailing Address: ***Be sure you have the correct address for mental health claims***

_____

Street Address City State Zip

Insurance Company Mental Health Phone Number: (____)_____

Deductible: $_____ **Has it been met?** _____

Co-payment (amount not covered by your insurance for each visit): $_____

Who will pay noninsured balance? _____

If you are required to get preauthorization, have you done so? _____

Authorization #: _____ **Number of visits authorized:** _____ **Effective dates:** _____

YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE PROVIDED ACCURATE INSURANCE INFORMATION. FAILURE TO DO SO WILL RESULT IN YOU BEING FULLY RESPONSIBLE FOR ALL CHARGES.

Signature: _____ **Date:** _____