## *Primary Insurance Information*

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 CORRECT ADDRESS FOR MENTAL HEALTH CLAIMS***

Street_________________________________ City_______________________________ State___ Zip__________

Insurance Company ***Mental Health*** Phone Number: (___) _____________________________________________________

Deductible: $_____________________________ Has deductible been met? ______________________________________

Copayment (amount you are responsible for at each visit): $ ____________________________________________________

Who will pay noninsured balance? ________________________________________________________________________

If you are required to get preauthorization for insurance coverage, have you done so? _________________________________

Authorization #: _____________________ Number of Visits Authorized: ____ Effective Date: ___________________________

## *Secondary Insurance Information*

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 CORRECT ADDRESS OF MENTAL HEALTH CLAIMS***

Street__________________________________ City ______________________________ State ___ Zip ____________

Insurance Company Mental Health Phone Number: (___) ___________________________________________________________

Deductible: $ ___________________________ ___Has it been met? ___________________________________________________

Copayment (amount you are responsible for at each visit): $ ________________________________________________________

Who will pay noninsured balance? ____________________________________________________________________________

If you are required to get preauthorization for insurance coverage, have you done so? ____________________________________

Authorization #: ______________________________ Number of Visits Authorized: _________ Effective Dates: ________________

***My signature below indicates that I have provided accurate insurance information. Failure to do so will result in my being fully responsible for all charges.***

Signature: ___________________________________________________ Date: __________________________________________