

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: \_\_\_\_\_