INSURANCE INFROMATION FORM

Patient Name: ____

Date of Birth: ___ / ___ / ____

Responsible Party: ______________________________

Address: ____

City: ___________________________ State: ______ Zip: ___________

Phone (Home): _________________ OK to leave message? Y N

Phone (Work): _________________ OK to leave message? Y N

Phone (Mobile): _________________ OK to leave message? Y N

Email: __________________________________ OK to leave message? Y N

Presenting Information: ____

____

____

____

Referred By: _________________________________

First Session: ____ / ____ / ____

INSURANCE INFORMATION

Carrier(s): Primary: __________________________________

Secondary: ________________________________

Insurance ID #: _______________________________ Group #: ______________________________

Name of Insured: _____________________________ DOB of Insured: ____ / ____ / ____

Secondary ID #: _______________________________ Insured: ______________________________

Diagnosis DX1: ______ DX2: ______ DX3: ______ DX4: ______

INSURANCE BILLING INFORMATION

Contact Person / Case Manager: ________________________

Pre Authorization for: _____ sessions, ending: _______

Number of Visits Per Contract Year: ____ Contract year Begins: ____ / ____ / ____

Annual Deductible: _______ Amount Met To Date: _____ Individual: _______ Family: _______

Excluded Diagnosis of Procedures: ____

Co-Payment: _________

Required Reports / Recertifications? ____