Client Insurance Form

(Please make additional copies of this form for additional insurance plans)

Please come prepared to show photo ID and your insurance card. Please use this form and have it available when you call your insurance company to check on benefits and request preauthorization, if needed.

Client Name: _____ DOB:_____

Client's Relationship with Insured (check one): ____Self; ____Spouse/Dom. Partner; ____Child; ____Other

Home Address: _____
Street

_____
City *State* *Zip*

INSURANCE INFORMATION: *(Please complete as much as you)*

May I contact the policy holder (insured) for this plan to ask questions about the insurance plan, or make clarifications about the billing policies? _____ Yes _____ No

Primary Insurance Provider/Company: _____

ID Number: _____ Group Number: _____

Insured Name: _____ DOB: _____

Insured Address: _____
Street

_____
City *State* *Zip*

Home Phone: _____ Work Phone: _____
(Area Code) *(Area Code)*

Insured's Employer: _____

Billing/Claims Address (See insurance card):

_____

Billing/Claims Phone Number (See insurance card): _____

Plan Effective Date: _____ Plan Renewal Date: _____

Number of Behavioral Health visits per year: _____ # of visits remaining: _____

Co-Pay: $_____ Benefits Being Used: _____ In-Network _____ Out-of-Network

Deductible Amount: $_____ Deductible Met for Year? _____ Yes _____ No

Preauthorization Required for Behavioral Health Benefits? _____ Yes _____ No
(We will do our best to check this for you, but it is in your best interest to check on authorization personally, also)

Contact Information for Preauthorization: _____

Authorization # (if applicable): _____

To be completed by Kimberly Christiansen, LPC, CADC III

Diagnosis Code: _____