



Health Insurance Form

Bring your insurance card to your first appointment.

It is highly recommended that you call the number on the back of your card to verify your plan's benefit coverage for outpatient behavioral health.

Name of Insured Member: _____ Member's Date of Birth: _____

Insured Member Address: _____

Name of Client: _____ Client's Date of Birth: _____

Client Address: _____

Insurance Plan: _____ ID #: _____

Mental Health Plan: _____ Group #: _____

Address for Claims: _____

_____ Phone #: _____

Preauthorization Required? Yes No Authorization # _____ Date _____

Co-pay amount: \$ _____ Co-insurance amount _____ % Sessions/year: _____

Deductible amount: \$ _____ Out of Pocket Maximum \$ _____ EAP: Yes No

Secondary Insurance: _____ ID #: _____