PRIMARY INSURANCE INFORMATION

COMPLETED BY CLIENT WHEN REGISTERING

Date: _____ Patient acct. # _____

Insurance Company: _____ Insurance Telephone #: _____

Type of Plan: _____ Clients Full Name: _____

Subscribers Name: _____ Group Number: _____

Subscribers Social Security #: _____ I. D. Number: _____

SECONDARY INSURANCE INFORMATION

COMPLETED BY CLIENT WHEN REGISTERING

Date: _____ Patient acct. # _____

Insurance Company: _____ Insurance Telephone: _____

Type of Plan: _____ Clients Full Name: _____

Subscribers Name: _____ Group Number: _____

Subscribers Social Security #: _____ I. D. Number: _____

OFFICE STAFF TO COMPLETE

PRIMARY INSURANCE BENEFITS

Spoke to: _____ Date: _____

Effective: _____ Copay: _____

In network insurance pays: _____ Out of network insurance pays: _____

Deductible amount: _____ Deductible already met: _____

Out of pocket amount: _____ Out of pocket amount: _____

% co-insurance applies after _____ % insurance will then pay at _____

Visits per calendar year: _____ Visits per contract year _____

Authorization: **Y** **N** # Sessions _____ Auth # _____ visits start _____ ending _____

Address for Claims: _____

_____

Comments: _____

_____

_____ _____

Provider specialty allowed by insurance? **Y** **N** credentials allowed: _____

Insurance verified by:

SECONDARY INSURANCE BENEFITS

Spoke to: _____ Date: _____

Effective: _____ Copay: _____

In network insurance pays: _____ Out of network insurance pays: _____

Deductible amount: _____ Deductible already met: _____

Out of pocket amount: _____ Out of pocket amount: _____

% co-insurance applies after _____ % insurance will then pay at _____

Visits per calendar year: _____ Visits per contract year _____

Authorization: **Y** **N** # Sessions _____ Auth # _____ visits start _____ ending _____

Address for Claims: _____

_____

Comments: _____

_____

_____ _____

Provider specialty allowed by insurance? **Y** **N** credentials allowed: _____

Insurance verified by: _____