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Insurance Information Sheet

Client Name:_____Client Date of Birth:_____

Insurance company name: _____

Primary or Secondary? (please check one): Primary _____Secondary _____

Policy Holder's name: _____ Policy Holder DOB:_____

Address: _____

Client's relation to policy holder (check one):

____self ____spouse/domestic partner ____child ____other

Home Phone:_____ Work Phone: _____

May I contact the policy holder for this plan to ask questions about the insurance plan, or make clarifications about billing policies? (check one) _____ yes _____no

Policy Holder's employer:_____

Policy Holder's plan name: _____

Billing/Claims Address (see insurance card): _____

City: State: Zip: _____

Phone #: _____

Identification#: _____

Group#: _____

Benefit Information: Plan effective date: _____Plan Renewal Date: _____

Unlimited Behavioral Health Benefits (check one)? _____ yes _____ no

If plan does not have unlimited benefits:

Number of visits per year: _____number of visits remaining: _____

Co-pay: Is this the in-network or out-of-network co-pay (check one)?

_____ In-network

_____ Out-of-network

Deductible amount: $ _____

Deductible met (check one)? ____yes ____no. If not met, how much remaining?_____

Preauthorization required? _____yes _____no.

Name and number of contact for preauthorization:_____

Authorization # (if applicable): _____