Health Insurance Form

Patient Name: _____ Phone: _____ (text Y N)

Address:_____

Email: _____ DOB: _____ Gender: M F

Employer: _____ Insured: self spouse child other

Ins Co: _____ Ins Plan Name: _____

Ins. ID: _____ Grp#: _____
Ins Plan # (not all plans have this) _____

Ins Provider benefit #: _____

If Insured not Self, then
Insured Name: _____ DOB: ____ Phone: _____
Address: _____

Patient or Authorized person's signature: I authorize the release of any medical or other information necessary to process this claim. Insured's or Authorized Person's Signature: I authorize payments of medical benefits to the undersigned physician or supplier of services described below.

Signature: _____ Parent/Guardian Sign.:_____

Date: _____ Date: _____

Supplier of Services: Cynthia Lee Shelton, LCSW

***** Office Only BENEFITS: Date checked: _____ Spoke with: _____**

Effective Date:_____ Calendar Yr: Y N Allowable amt: _____
Co-ins: _____ Co- Pay: _____ Deductible: _____ Deductible Used: _____

OOP Max: _____ # visits per calendar Year: _____

Precert Req: y n If yes, #approved visits _____
Physician Referral y n
(If Yes) Physician Name: _____ Phys. Phone: _____