SUBSCRIBER AND CLIENT INFORMATION FORM

This information is necessary for billing your insurance company. Please fill it out as completely as you can. If you have any questions, please feel free to ask. The **CLIENT** is the person who is being seen and the **SUBSCRIBER** is the person named on the insurance card.

Date_____ **Are you updating information from an earlier form?** NO☐ YES☐

CLIENT / PATIENT

Client is (check all that apply): Employed☐ **Single**☐ **Married**☐ **AdultStudent**☐

Birthdate_____ **Gender F**☐ **M**☐ **Relation to Insured: Self**☐ **Spouse**☐ **Dependent**☐ **Other**☐

Last Name_____ **First Name**_____ **Middle**_____

Street Address_____ **Best Phone:** (Hm Wk Cell) (_____

City_____ **State**_____ **Zip**_____ **Email**_____

SUBSCRIBER / INSURED PERSON

Birthdate_____ **Gender F**☐ **M**☐

Last Name_____ **First Name**_____ **Middle**_____

Street Address_____

City_____ **State**_____ **Zip**_____

Phones: (home) (_____ (work) (_____ (cell) (_____

Name of Employer or Group _____

PRIMARY INSURANCE INFORMATION - Indicate Secondary Insurance on the "Supplemental Insurance Form"

INSURANCE TYPE(check one): BlueCross☐ **Medicare**☐ **MedAdv**☐ **BCNetworkHMO**☐ **Commercial**☐ **FEP**☐

If MEDICARE PRIMARY: Medicare HIC#_____ **(ignore information below)**

ALL PRIMARY INSURANCE OTHER THAN MEDICARE (please CONFIRM address where claims are to be sent):

Group#_____**Contract/Policy#** _____ **(contract/policy# REQUIRED for processing)**

if Commercial: Carrier Name_____

Address_____ **City** _____ **State**____ **Zip** _____

Prior Authorization Number _____ **SECONDARY INSURANCE EXISTS**☐ **(see over)**

THERAPIST USE ONLY (this is REQUIRED for processing)

Provider Name _____

Procedure Code_____ **Diagnosis (ICD9)**_____ **Session Charge $**_____

(If group therapy, No. of people in session _____ **)** **(if different from regular fee schedule)**

Condition related to: Employment☐ Auto accident☐ Other accident☐ Accident was in St/Prov_____ on date_____

Place of Service: Office☐ Pt Home☐ IP Psych☐ OP Psych☐ Partial Psych☐ Other☐

If IP, Name/address of facility: _____