Weekend Behavioral Health

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Insurance Information Form

Client Name: _____ Date of Birth: _____

Client Address: _____

Client Phone: Home: _____ Work: _____ Cell: _____

Client SS#_____ Client gender: _____ Client marital Status: _____

Policy Holder Name: _____ Date of Birth: _____
Relationship to Client (spouse, child, parent, legal guardian, other): _____

Policy Holder Address: _____

Policy Holder Phone: Home: _____ Work: _____ Cell: _____

Policy Holder Date of Birth: _____ Policy Holder SS#_____

Policy Holder Gender: _____ Policy Holder Marital Status: _____

Policy Holder's Employer: _____

Name of Insurance Company: _____

Type of Policy: (HMO, PPO, Indemnity, EAP, other): _____

Member ID #: _____ Group #: _____

Phone number for benefits verification: _____

Does your insurance company have mental health benefits? _____
Deductible Amount: _____ Copay: _____

Number of sessions covered by insurance company? _____

Primary care Physician: Name: _____

Phone: _____ Address: _____

Client or responsible party (if application) Initial: _____

Client name (please print): _____ Date: _____

Client name's signature: _____

Responsible party (please print): _____ Date: _____

Relationship between responsible party and client: _____

Responsible party name's signature: _____

Client or responsible party (if application) Initial: _____