

INSURANCE INFORMATION

Please fill out, print and fax to Julie at 732-873-5588, phone #732-873-5570

TODAY'S DATE: _____ **SEEKING APPT. WITH:** _____

YOUR NAME: _____ **YOUR PHONE #** _____

FULL NAME OF CLIENT: _____ **DOB OF CLIENT:** _____

FULL ADDRESS OF CLIENT: _____

NAME OF INSURED: _____ **DOB OF INSURED:** _____

FULL ADDRESS OF INSURED: _____

SS# OF INSURED: _____ **PHONE NUMBER OF INSURED:** _____

INSURANCE CARRIER: _____

INSURANCE ID #: _____

INSURANCE PHONE # FOR MENTAL HEALTH BENEFITS: _____

THE BELOW IS TO BE COMPLETED BY THE DOCTOR'S OFFICE

EFFECTIVE DATE: _____

DEDUCTIBLE: _____ **# MET THIS YEAR?:** _____

CO-INSURANCE _____ **# OF AUTHORIZED SESSIONS** _____

AUTHORIZATION BY: _____ **APPROVAL #:** _____

CLAIMS ADDRESS: _____

REF# TO CALL: _____

ALLOWABLE FEES: _____