



## Insurance Information

Date: \_\_\_\_\_

**Patient's** name: \_\_\_\_\_

**Patient's** date of birth: \_\_\_\_\_

Relation to insured: \_\_\_\_\_

**Subscriber/Insured's** name: \_\_\_\_\_

**Subscriber's** date of birth: \_\_\_\_\_

Address for claims: \_\_\_\_\_

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Which BC/BS policy does subscriber have? \_\_\_\_\_

Policy #: \_\_\_\_\_

Group #: \_\_\_\_\_

Effective date of policy: \_\_\_\_\_

What is your copayment for mental health services? \_\_\_\_\_  
(copayments are due at time of service)