

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 _____

City _____ State _____ Zip _____

SUBSCRIBER / INSURED PERSON

Birthdate _____ Gender F M

Last Name _____ First Name _____ Middle _____

Street Address _____

City _____ State _____ Zip _____

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

Name of Employer or Group _____

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

INSURANCE TYPE (check one): BlueCross Medicare BCNetworkHMO Commercial FEP
(ONLY if billing BCN directly!)

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 group _____) (if different from regular fee schedule)

Place of Service: Office IP Psych OP Psych Partial Psych Other

If IP, Name/address of facility: _____