

Insurance Information

Section 1 – Insured Information

Patient Relationship to Insured: Self Spouse Child Other

If "Patient Relationship to insured" is other than "Self" please complete the following. If patient is the insured go directly to Section II.

Insured's Name	Birthdate	Age	S.S.#
Address	City		Zip
Home Phone	Employer		Work Number
Marital Status	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Employment Status	

Section 2 – Insurance Policy Information

Medical ChampUS ChampVA Group Health Plan FECA Other

Insurance Company			
Address	City	State	Zip
Plan Name	Policy Number		Group Number

Is the patient covered by more than one insurance?

Yes – Please complete Section 3 No – Please go to Section 4

Section 3 – Secondary Insurance Policy Information

Medical ChampUS ChampVA Group Health Plan FECA Other

Insurance Company			
Address	City	State	Zip
Plan Name	Policy Number		Group Number

Section 4 – Billing Information

(Complete only if there is no insurance coverage)

Who is responsible for charges for this patient? Patient – Please sign and return
 Other – Please complete the following information

_____	_____	_____	_____
Name	Birthdate	Age	S.S.#
_____	_____	_____	_____
Address	City	State	Zip
_____	_____	_____	_____
Home Phone	Employer	Work Number	
_____	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	_____	_____
Marital Status		Employment Status	

Medical Release Statement

I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to Selah Counseling Services.

_____	_____
Signature	Date

Payment Release Statement

I authorize payment of medical benefits to Selah Counseling Services for services rendered.

_____	_____
Signature	Date