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

_____ Gender ____ Male ___ Female _____
Marital Status Employment Status

Section 2 – Insurance Policy Information

___ Medical ___ ChampUS ___ ChampVA ___ Group Health Plan ___ FECA ___ Other

_____ ___ HMO ___ PPO
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 ____ Male ___ 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