

PLEASE DO NOT STAPLE IN THIS AREA

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

**HEALTH INSURANCE CLAIM FORM**

PICA PICA

1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> CHAMPUS <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN (SSN or ID) <input type="checkbox"/> FECA BLK LUNG (SSN) <input type="checkbox"/> OTHER (ID) <input type="checkbox"/>	1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)		3. PATIENT'S BIRTH DATE MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>
5. PATIENT'S ADDRESS (No., Street)		4. INSURED'S NAME (Last Name, First Name, Middle Initial)
6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>		7. INSURED'S ADDRESS (No., Street)
CITY	STATE	8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>
ZIP CODE	TELEPHONE (Include Area Code)	9. PATIENT STATUS Employed <input type="checkbox"/> Full-Time Student <input type="checkbox"/> Part-Time Student <input type="checkbox"/>
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		10. IS PATIENT'S CONDITION RELATED TO:
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (CURRENT OR PREVIOUS) <input type="checkbox"/> YES <input type="checkbox"/> NO	11. INSURED'S POLICY GROUP OR FECA NUMBER
b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>	b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO PLACE (State) _____	a. INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>
c. EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO	b. EMPLOYER'S NAME OR SCHOOL NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE	c. INSURANCE PLAN NAME OR PROGRAM NAME
<b>READ BACK OF FORM BEFORE COMPLETING &amp; SIGNING THIS FORM.</b>		d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO <i>If yes, return to and complete item 9 a-d.</i>
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE 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 the party who accepts assignment below.  SIGNED _____ DATE _____		13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.  SIGNED _____
14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE	17a. I.D. NUMBER OF REFERRING PHYSICIAN	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY
19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES _____
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE) 1. _____ 3. _____ 2. _____ 4. _____		22. MEDICAID RESUBMISSION CODE _____ ORIGINAL REF. NO. _____
23. PRIOR AUTHORIZATION NUMBER _____		24. TABLE
24. TABLE		25. FEDERAL TAX I.D. NUMBER _____ SSN EIN <input type="checkbox"/> <input type="checkbox"/>
25. FEDERAL TAX I.D. NUMBER _____ SSN EIN <input type="checkbox"/> <input type="checkbox"/>		26. PATIENT'S ACCOUNT NO. _____
26. PATIENT'S ACCOUNT NO. _____		27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input type="checkbox"/> YES <input type="checkbox"/> NO
27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input type="checkbox"/> YES <input type="checkbox"/> NO		28. TOTAL CHARGE \$ _____
28. TOTAL CHARGE \$ _____		29. AMOUNT PAID \$ _____
29. AMOUNT PAID \$ _____		30. BALANCE DUE \$ _____
30. BALANCE DUE \$ _____		31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)  SIGNED _____ DATE _____
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)  SIGNED _____ DATE _____		32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)
32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)		33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #  PIN# _____ GRP# _____
33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #  PIN# _____ GRP# _____		

## Insurance Questionnaire / Payment Agreement

In order to determine what insurance benefits you have available, we *require* you to contact your insurance company at the phone number listed on your insurance card, and ask (and enter below) the following information. **Failure to fill this form out COMPLETELY will disable us from billing your insurance provider for services rendered. It is your responsibility for any outstanding balance.** Psychological Services and Therapy is a *confidential* process to which we are legally and ethically bound. However, if you file for insurance benefits or reimbursement, please be aware that your confidentially may be compromised.

Once you have filled this form out, please return as soon as possible. Please, ask the following questions.

### **“I AM CALLING TO CHECK MY PSYCHOTHERAPY BENEFITS.”**

(Be sure you are transferred to the mental health department, not medical)

1. Is Dr. Valerie Maxwell a provider under my plan?      Yes / No
  
2. Deductible (if none, enter “0”): \$ \_\_\_\_\_
  - a. (If #2 is not 0) Has the Deductible been met?      Yes / No
  
3. Do I need an authorization for mental health?      Yes / No
  - a. (If #3 is Yes) What is the authorization number? \_\_\_\_\_
  - b. (If you have an authorization #) How many sessions are authorized to start? \_\_\_\_\_
  - c. What is the start and end dates of the authorized sessions? Start \_\_\_\_\_ End \_\_\_\_\_
  
4. What is the maximum number of sessions I’m authorized to use? \_\_\_\_\_
  
5. What is my co-payment? \_\_\_\_\_
  
6. Address to sent Mental Health Claims:      7. Address to send Treatment Reports (to Insurance Co):
  
- \_\_\_\_\_
- \_\_\_\_\_
  
8. Phone # Called: \_\_\_\_\_      Date of Call: \_\_\_\_\_

**I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO PAY FOR SERVICES NOT COVERED BY MY INSURANCE, WHETHER BECAUSE I FAILED TO OBTAIN AUTHORIZATION, DENIAL, OR LIMITATION OF BENEFITS, CO-PAY, ETC. I HEREBY UNDERSTAND THAT IF I HAVE AN OUTSTANDING BALANCE, I WILL MAKE ARRANGEMENTS TO PAY THE AMOUNT DUE.**

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Client Name (Print)