

Billing Form

Client Name _____ Referred by: _____

Address _____

Home Phone _____ Work Phone _____ Cell Phone _____

Social Security Number _____ Date of Birth _____

Employer or School Name _____ Email _____

Insured Name/Responsible Party _____

Relationship to Client: _____ Address: _____

Home Phone _____ Work Phone _____ Cell Phone _____

Social Security Number _____ Date of Birth _____

Employer or School Name _____ Email _____

Name of Insurance _____ Toll Free Number _____

ID Number _____ Group Number _____

Claims Address _____

Secondary Insurance? Yes/No Per your request, I will provide documentation for you to bill on your own.

Questions to ask your insurance company about "Outpatient Mental Health Benefits":

Is a referral required? Yes / No By whom? _____ (You are responsible for obtaining)

What is the co-pay or co-insurance? _____ Effective date of insurance? _____

Is there a deductible? Yes / No What is it? _____ How much has been met? _____

How many sessions are allowed per calendar year? _____ How many have been used? _____

Notes _____

