CLIENT INSURANCE BENEFIT INFORMATION

Light the Way Christian Counseling Center
221 Fountain Place
Bellefontaine, OH 43311
Tax ID – 34-4435841

Date: _____

Client #: _____

Client Name: _____ SS#: _____ DOB: _____

Address: _____ Phone: _____

_____

Employer &/or School: _____ Marital Status: _____

Primary Insured: _____ SS#: _____ DOB: _____

Address: _____ Phone: _____

Employer: _____ Relationship to client: _____

Insurance Name & Address: _____

Policy/ID #: _____ Group #: _____ Insurance Phone: _____

Secondary Insured: _____ SS#: _____ DOB: _____

Address: _____ Phone: _____

Employer: _____ Relationship to Client: _____

Insurance Name & Address: _____

Policy/ID #: _____ Group #: _____Insurance Phone:_____

INSURANCE AUTHORIZATION

I request that payment under the medical insurance program be made either to me or to the provider named above on the bills for services furnished me. I authorize the above named provider to release to the Social Security Administration, or intermediaries, insurance companies or carriers any information needed for this claim or related Medicare claim. I further permit a copy of the authorization be used in place of the original. This authorization is to apply to all private insurance claims for my mental health treatment or that of my child.

Date: _____ _____

Patient's signature or authorized representative

Deductible: _____ Date Satisfied: _____

Reimbursement Rate (after deductible): _____ Yearly Max. Benefits: _____

Prior Authorization: Y N Precert phone #: _____ Auth #: _____

Submit claims to: _____

Name of Contact: _____

Negotiated Maximum Family Co-pay: _____ DX:_____