

## Secondary Insurance Information

If you have a secondary health insurance plan that you would like us to bill on your behalf, please complete this page. Please note that agency policy is that we will bill a secondary policy only from the date the information is provided on, we will not retroactively bill any secondary policy. We will, however, provide you with the necessary information in order that you may bill your secondary policy yourself. You are responsible for the portion not paid by either your Primary or Secondary policy. Knowingly providing false or inaccurate information may be considered insurance fraud. **Please present your health card to your therapist so that a photocopy may be made. If you are unable to provide us with adequate information with which we can bill your health insurance, all charges will be billed directly to you**

Medicare

Champus

ChampVA

Group Plan

FECA/Black

Other

INSURED'S Name (Last, First, Middle Initial)

Address

City

State

Zip

Telephone Number (with area code)

INSURED'S Social Security #

INSURED'S Birthdate

Sex

Male

Female

Health Plan ID#:

Insurance Company:

Policy Plan Name:

Group Number:

Insured's Employer (Company Name):

Insurance Telephone Number:

Insurance Claims Address:

Patient's Relationship to Insured:

Self

Spouse

Child

Step Child

Other

If there are any changes to the above information, please let your therapist know as soon as possible. Use of insurance requires us to release a diagnosis to your insurance company. Some insurance companies require additional information. We cannot guarantee that information released to other parties will remain confidential.

PATIENT'S or AUTHORIZED PERSON'S SIGNATURE:

I authorize the exchange of any medical or other information necessary to process this claim or to determine eligibility, including number of available sessions. I also request payment of benefits either to myself or the part who accepts assignment.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

INSURED'S or AUTHORIZED PERSON'S SIGNATURE:

I authorize payment of medical benefits to **Sharon Eiler, MA, LMFT**

Signed: \_\_\_\_\_ Date: \_\_\_\_\_