

Insurance Information

Name: _____ Date of Service: _____

Address: _____ Date of Birth: _____

_____ Phone Number: _____

Client Social Security Number: _____

Primary Insurance Company: _____

Primary Insurance Address: _____

Primary Insurance Phone Number: _____

Primary Insurance Authorization No.: _____

Primary Insurance ID Number: _____

Primary Insurance Group Number: _____

Secondary Insurance Company: _____

Secondary Insurance Address: _____

Secondary Insurance Authorization No. _____

Secondary Insurance Phone Number: _____

Secondary Insurance ID Number: _____

Secondary Insurance Group Number: _____

Relationship to Insured: _____

Referring Physician (if applicable): _____ Phone: _____

Referring Insurance Company (if applicable): _____

Phone Number: _____

Employee Assistance Program (EAP) Name: _____

EAP Authorization Number: _____

EAP Contact: _____ **Phone Number:** _____