Secondary or Alternative Insurance Payors

1. SECONDARY INSURANCE

Does the back of your card indicate a phone number to call for Mental Health (MHSA)? ❒ Yes ❒ No
Insurance Company: _____ Copay Amount: _____
Insurance Phone #: _____ Group #: _____ ID #: _____
Policy Holder Name: _____ Social Security #: _____
Relation to Patient: _____ Date of Birth: _____ Gender: ❒ M ❒ F
Address (if different from patient): _____
Effective Date:_____Policy Holder Employed by: _____

2. EAP INFORMATION

EAP Company:_____ Employer: _____
Authorization #:_____ # of Sessions Authorized: _____ Dates Authorized:_____
Claims Address: _____

3. WORKERS COMP or AUTO ACCIDENT CLAIM or CRIME VICTIM REPARATION

Insurance Name: _____ Claim #: _____
Claims Address: _____
City: _____ State: _____ Zip Code: _____
Adjuster Name: _____ Adjuster Phone #: _____
Adjuster Email: _____ State Accident Occurred In: _____

Date of Accident: _____ Brief Description of Accident: _____
_____
_____
_____

4. NAME/ ADDRESS/ EMAIL/ PHONE NUMBER OF ALTERNATIVE PAYOR?

_____
_____
_____

5. WHAT RELATION IS THE ALTERNATIVE PAYOR TO YOU?

_____
_____
_____

Signature of Responsible Party: _____ **Date:** _____

Please Print Name of Responsible Party: _____

Please Print Name of Patient: _____ **DOB:**_____