

**Tamara Anderson LMHC**

Today's Date: \_\_\_\_\_

If you would like me to bill your insurance please complete the following form.

**All blanks** must be completed

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_ M/F circle

Address: \_\_\_\_\_ Apt #: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_

Employer: \_\_\_\_\_ SSN: \_\_\_\_\_

**Subscriber Information: Complete for Subscriber if different than above.**

Subscriber Name: \_\_\_\_\_

Subscriber Address: \_\_\_\_\_

Subscriber DOB: \_\_\_\_\_ Subscriber SSN: \_\_\_\_\_

Subscriber's Employer: \_\_\_\_\_

**Insurance Information:**

Insurance Company: \_\_\_\_\_

Member Services Phone #: \_\_\_\_\_

Do You Need a Referral: \_\_\_\_\_ If Yes, do you have it?: \_\_\_\_\_

Member/ID# : \_\_\_\_\_ ( include all Alpha Characters) Group#: \_\_\_\_\_

Please indicate here if it is okay for the billing office to contact you if needed: \_\_\_Y\_\_\_N

**SIGNATURE ON BOTH LINES REQUIRED IN ORDER TO SUBMIT INS. CLAIM**

PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE:

I agree to be responsible for payments of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made. I further authorize the release of any medical or other information necessary to process insurance claims.

**SIGNED** \_\_\_\_\_ **DATE** \_\_\_\_\_

INSURED'S OR AUTHORIZED PERSON'S SIGNATURE:

I authorize payment of medical benefits to the above named health care provider for services described. I also request payment of government benefits to the party who accepts assignments.

**SIGNED** \_\_\_\_\_ **DATE** \_\_\_\_\_