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:_____

Email Address: _____

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_____