Williamsburg COUNSELING

INSURANCE INFORMATION

If you would like to use insurance for our services, please complete this form.

Date:_____

Insured's information:

Insured's Name:_____

Address:_____
Street/PO Box City State Zip

Phone#: Hm: _____ Wk:_____ Cell:_____

Insurance Company: _____

Insurance Company phone #:_____

Insured's Member ID #: _____

Insured's DOB _____

Patient's information (complete only if different from Insured's):

Insured's Name:_____

Address:_____
Street/PO Box City State Zip

Phone#: Hm: _____ Wk:_____ Cell:_____

Insurance Company: _____

Insurance Company phone #:_____

Patient's Member ID #: _____

Patient's DOB _____

If your insurance company requires authorization, please call the member services number on your card for an authorization number. If you are unsure, please call them in advance.

If you do not know your co-pay, please call your insurance company in advance.

Auth # _____ **Co-pay**_____