



Insurance Information

Today's Date: _____

Patient's name: _____

Patient's date of birth: _____

Patient's relation to insured: _____

Subscriber/insured's name: _____

Subscriber's date of birth: _____

Subscriber's address: _____

Which BC/BS policy does subscriber have? _____

Policy #: _____

Group #: _____

Effective date of policy: _____

What is your copayment for mental health services? _____