

Secondary Insurance carrier: _____ Insurance Phone No.: _____

Insurance Claims mailing address: _____

Subscriber Name: _____ Subscriber SS # _____ DOB: _____

Identification No.: _____ Group No.: _____ Co-Pay \$ _____

Client's relationship to subscriber: (circle one) Self Spouse Child Partner Other

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the provider. I understand that I am financially responsible for any balance. I also authorize Linda Levi, LCPC or Tri-County Medical Billing staff to release any information required to process my claims.

Signed: _____ Date: _____