INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY: ____

INSURANCE ADDRESS: ____

CUSTOMER SERVICE PHONE NUMBER ON BACK OF CARD: ______________________________

POLICY HOLDER'S NAME: ____________________________ BIRTH DATE:____________________

MEMBER ID NUMBER:__________________________________

GROUP NUMBER: __________________

VERIFICATION OF INSURANCE BENEFITS: (Call # on back of your insurance card and ask the below questions. What is the # you called? __________________. Please ask for the name of the person you spoke to: ___________).

1. Is my mental health benefits covered by a different insurance company? Yes No
2. If different, please use the below secondary insurance area to clarify the name, phone number and Policy number.
3. Do I require any authorization or referral to see a clinician at the 634 Magazine St. address? Yes No If yes, please include authorization # here _____________.
4. What is my deductible? _____What amount of the deductible have I met? ______ What month each year does my annual deductible begin? ___________________.
5. What is my copay per visit? ________.
6. How many sessions per year are allowable under my plan? ________________.

SECONDARY INSURANCE COMPANY: ____

ADDRESS/PHONE: ____

POLICY HOLDER'S NAME: ____________________________ BIRTH DATE:____________________

POLICY NUMBER: __________________________________ GROUP NUMBER: _________________

ASSIGNMENT OF INSURANCE BENEFITS

In regards to services rendered to me by the provider listed below, I, _______________________________ authorize the insurance company(s) listed above to pay medical benefits directly to New Orleans Center for Mind Body Health. In the event that coverage is denied or charges are applied to deductible, I agree to assume full financial responsibility for the charges incurred. Furthermore, I authorize Dr. Griffies to release any or all information contained in my medical file to the above listed company(s) for the purposes of obtaining authorization and/or billing procedures.

PATIENT NAME (PLEASE PRINT): ____

PATIENT'S SIGNATURE: ____

DATE: ___________________________ WITNESS: ____