HELEN MUSCOLO, MA, MFT

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INSURANCE INFORMATION FORM

Insured ID Number: ____________________ **Policy Group #:** __________________

Insurance plan name (Blue Cross, Aetna, etc): ______________________________

Insured's name: ____

Insured's address: ____
Street address

______________ __________ _______________
City / State **Zip code** **Phone**

Insured's date of birth: _________________

Patient's name (if different): ____

Patient's address: ____
Street address

______________ __________ _______________
City / State **Zip code** **Phone**

Patient's date of birth: _________________

Is there another health benefit plan? (yes or no): _______

I authorize the release of any medical or other information necessary to process health insurance claims. I authorize payment of medical benefits to the provider listed above.

____________________________________ _______________
Patient or Authorized Person's Signature **Date**