John Beck, LCPC

DSM # _______________ Date _________________

Insurance Claim Form

Please complete insurance claim form if you intend to have your insurance billed.

Client's Name:___________________________________Birthdate: ___________Sex: M / F

Address:__________________________________City________________________Zip:__________

Home phone: _______________Cell phone:_________________email:______________________

Social Security Number:____

Insurance Name:____

Claims Address:________________________________City:________________Zip:__________

Policy #:__________________________________Group:___________________________________

Insurers Name: (other than you)____

Insurers Birthdate:__/______/______Sex: M/F

Relationship to insured person: self______Spouse _______Parent ________other:_________

Is there another benefit plan? Yes / No (if there another insurance please put it on the back)

We must have your signature on file to bill your insurance company. Please sign in both places.

I authorize the release of medical or other information necessary to process this claim. I also request payments of medical benefits.

Client or authorized person:____________________________________Date:_________________

I authorize benefit payments to John Beck LCPC for services provided:

Client or authorized signature:__________________________________Date:_________________