Comprehensive Psychiatry Group, Inc.

INSURANCE INFORMATION

☐ No Change in Insurance Account # _____

Patient Name: _____ Soc. Sec. #: _____ DOB: _____

Address: _____
Street Address City State Zip Code

Phone: (____) _____ ❑ Cell ❑ Home ❑ Work E-mail: _____

Emergency Contact: _____ Phone: _____

PRIMARY INSURANCE: Relationship to Patient: ❑ Self ❑ Spouse ❑ Child

Insured Name: _____ Soc. Sec. #: _____ DOB: _____

Address: ❑ same _____
Street Address City State Zip Code

Phone: (____) _____ ❑ Cell ❑ Home ❑ Work E-mail: _____

Insurance Company/Address: _____

Insurance ID# _____ MMIS# _____

SECONDARY INSURANCE: Relationship to Patient: ❑ Self ❑ Spouse ❑ Child

Insured Name: _____ Soc. Sec. #: _____ DOB: _____

Address: ❑ same _____
Street Address City State Zip Code

Phone: (____) _____ ❑ Cell ❑ Home ❑ Work E-mail: _____

Insurance Company/Address: _____

Insurance ID# _____ MMIS# _____

I HEREBY AUTHORIZE **CPG** TO RELEASE TO MY INSURANCE COMPANY, ALL MEDICAL INFORMATION NECESSARY IN ORDER TO PROCESS MY MEDICAL CLAIMS. I REQUEST THAT PAYMENT OF AUTHORIZED BENEFITS BE MADE ON MY BEHALF & ASSIGN THE BENEFTS PAYABLE FOR SERVICES RENDERED TO ME AND / OR MY DEPENDENTS TO **COMPREHENSIVE PSYCHIATRY GROUP, INC.** TO SUBMIT A CLAIM ON MY BEHALF.

_____ _____
Insured's Signature (sign or type full name) Date