Integrative
Trauma Treatment Center

Insurance Information for Verification of Benefits

Client Name: _____ Client Date of Birth: _____/_____/_____

Therapist: _____ Client Phone #: ( ) _____ - _____

I. Primary Insurance Co.: _____

Policy Holders Name: _____ Policy Holders Date of Birth: _____

Policy Holders Address: _____ City/State/Zip: _____

ID Number: _____ Group Number: _____

Client Relationship to Primary Insured: SELF___ SPOUSE___ CHILD___ OTHER_____

II. Secondary Insurance Co.: _____

ID Number: _____ Group Number: _____

Client Relationship to Secondary Insured: SELF___ SPOUSE___ CHILD___ OTHER_____

Policy Holders Name: _____ Policy Holders Date of Birth: _____

Policy Holders Address: _____

List persons authorized to discuss your billing account with Integrative Trauma Treatment Center and Sunrise Medical Billing including but limited to making payments, supplying service dates, providing account status, arranging payments and/or disclosing billing information.

1) _____ (relationship to client) _____

2 _____ (relationship to client) _____

3) _____ (relationship to client) _____

Additionally, I authorize the release of any medical or other information necessary to process claims. I understand I am responsible for any charges not covered by my insurance. I also request payment of government benefits either to myself or the party who accepts assignment. My signature also indicates that I authorize payment of medical benefits to the provider of services and the entity therein.

***PLEASE PROVIDE A COPY OF YOUR INSURANCE CARD TO OUR OFFICE MANAGER OR YOUR PROVIDER

SIGNATURE: _____ DATE: _____