HEALTH INSURANCE ADVOCATES

Patient Information and Insurance Form
(Please Print and All Sections Must be Completed)

Organization Name: 3D TEEN RECOVERY

Patient Information:

Legal Name:	Date:

Address:	City:	State:	Zip:

Telephone:		Marital Status: (circle)
Home:	Cell:	Married Single Widow Divorced

Date of Birth: (MM/DD/YEAR)	Social Security # (Not Req):	Sex: (circle)
		Male Female

E-mail Address:

Insurance Information: ***Please Provide Copy of Insurance Card Front & Back***

Note: ALL UNITED HEALTH CARE AND SUBSIDIARY POLICES REQUIRE VERBAL CONSENT PRIOR TO REQUEST A REFERENCE NUMBER FROM THE CALL WILL BE NEEDED

Name of Insurance:	Insurance Provider Phone #:	Subscriber's Name:

Subscriber's Sex: (circle)	Subscriber's SS # (Not Req):	Relationship to Patient: (ie. Self, Child, Spouse)
Male Female		

Subscriber's Address on File with Insurance Carrier:	City:	State:	Zip:

Subscriber's Group#:	Subscriber's ID#:

Subscriber's Date of Birth: (MM/DD/YEAR)	Individual or Group Plan:

Behavioral Health Phone#:	Precertification Phone#: