



**PRESCREEN INSURANCE INFORMATION**

Please provide a copy of the front and back of your insurance card if emailing this to your therapist. If you are bringing this form with you, please have your card available.

1. **Client's name:** \_\_\_\_\_
2. **Date of Birth:** \_\_\_\_\_
3. **Contact phone number:** \_\_\_\_\_
4. **Home address:** \_\_\_\_\_
5. **Date authorization initiated:** \_\_\_\_\_
6. **Name of Insurance Company:** \_\_\_\_\_
7. **Insurance ID# of client:** \_\_\_\_\_
8. **Phone number to call for mental health or provider services** (located on back of insurance card): \_\_\_\_\_
9. **Relationship to insurance subscriber** (if not client): \_\_\_\_\_
10. **Subscriber information** (if not client):  
**Name:** \_\_\_\_\_  
**DOB:** \_\_\_\_\_                      **Gender:** \_\_\_\_\_  
**Address:** \_\_\_\_\_  
\_\_\_\_\_
11. **Name and phone number of the person who referred you:** \_\_\_\_\_  
\_\_\_\_\_
12. **Emergency contact person (name and phone numbers):** \_\_\_\_\_  
\_\_\_\_\_
13. **Person financially responsible for making any insurance co-payments/deductibles:**  
\_\_\_\_\_
14. **Copay:** \_\_\_\_\_