Samaritan
Center of Puget Sound
formerly Presbyterian Counseling Service

INSURANCE INFORMATION

Client: First Name_____M.I._____Last Name_____

Social Security # _____-_____-_____ Birth Date _____________ Gender: M ☐ F ☐

Marital Status: Single ☐ Married ☐ Other ☐

Employment Status: Employed ☐ Full-Time Student ☐ Part-Time Student ☐

If there is a specific injury or illness which precipitated coming for counseling: _____

Is patient's Condition Related to: Employment ☐ Auto Accident ☐ Other Accident ☐

State in which occurred _____

Date of current injury or illness ______________ Date of same or similiar condition ___________

Work lost due to current condition from _______________ to _______________

Hospitalization due to current condition from _______________ to _______________

Client or Authorized Person's Signature:

I authorize payment of medical benefits to Samaritan Center of Puget Sound..

Signed_____ Date_____

I authorize the release of any medical or other information necessary to process this claim or any further claims. I also request payment of government benefits either to myself or to the party who accepts assignment below.

Signed_____ Date_____

To be completed by therapist

Therapist:_____ Provider Number:_____

Prior authorization number (if required):_____

Diagnosis: _____ _____ _____

CPT (Procedure) Codes:_____

In which office will this client be seen? _____

FOR OFFICE USE ONLY:

Insurance carrier:

Coverage:

$_____Client Co-Pay

_____% Client

_____% Payment

$_____Deductible ☐ Met

$_____Remaining

_____ # of Sessions ____ # Remaining

Policy Effective and End Date:_____

Referral: ☐ None Needed ☐ P.C. Physician

Comments:

_____

_____

_____

Authorization:

☐ None ☐Regence ☐ Value-Options ☐ UBH

Other _____

Authorization #:_____

# of Sessions Auth. _____

Authorization Date From: _____

☐ Fee Schedule Unavailable

Code	Allowed	% Amt	Code	Allowed	% Amt
☐ 90791	$_____	/_____	☐ 90832	$_____	/_____
☐ 90834	$_____	/_____	☐ 90837	$_____	/_____
☐ 90847	$_____	/_____	☐ 90846	$_____	/_____

Comments:

_____

_____

_____

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Client Name: _____

Insurance Company Information -- Primary Coverage

First Name_____M.I._____Last Name_____

Address_____

City_____ State_____ Zip_____

Home phone_____ Work phone_____

Policy Holder Information *(complete section below **IF** policy holder is not client - **OR** - copy of card is not present)* :

Birth Date _______________ Gender: M ☐ F ☐

Client relationship to Insured: Self ☐ Spouse ☐ Child ☐ Other ☐

Under employer's health plan? *Circle one* Y N Insured's Social Security # _____ - _____ - _____

Employer Name_____

Ins Co. Name_____ Phone number _____

Address_____

City_____ State_____ Zip_____

ID number _____ Group number_____

Insurance Company Information -- Secondary Coverage

If there is another health benefit plan, complete the following.

Other Insured Information:

First Name_____M. I._____ Last Name_____

Birth Date _______________ Gender: M ☐ F ☐

Client relationship to Insured: Self ☐ Spouse ☐ Child ☐ Other ☐

Under employer's health plan? *Circle one* Y N Insured's Social Security # _____ - _____ - _____

Employer Name_____

Ins Co. Name_____ Phone number _____

Address_____

City_____ State_____ Zip_____

ID number _____ Group number_____