Kyle Lee Williams, MA, LMHC
PATIENT INSURANCE CLAIM INFORMATION FORM

(Please Print)

Today's date:	

PATIENT INFORMATION

Patient's last name:	First:	Middle:	Marital status (circle one) Single / Mar / Div / Sep / Wid
Street Address:			P.O. Box
City:	State:		ZIP Code:

Birth Date: / /	Age:	Sex: ❑ M ❑ F	Social Security No.:	Home Phone No.: ( )	Cell Phone: ( )

Occupation:	Employer:	Employer Phone No.: ( )

INSURANCE INFORMATION

(Please submit with a copy of your insurance card(s) (front & back)

Is this patient covered by insurance? ❑ Yes ❑ No

Please indicate primary insurance	❑ Premera	❑ Asuris	❑ Molina	❑ Tricare	❑ Group Health

❑ Aetna	❑ Cigna	❑ Medicare	❑ United Health Care	❑ Other

Subscriber's name:	Subscriber's SSN:	Birth date: / /	Group no.:	ID no.:

Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other

Name of secondary insurance (if applicable)

Subscriber's name:	Birthdate: / /	Group no.:	ID no.:

Occupation:	Employer:	Employer phone no.: ( )

Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other

Person responsible for bill:	Birth date: / /	Address (if different):	Home phone no.: ( )

Occupation:	Employer:	Employer address:	Employer phone no.: ( )

IN CASE OF EMERGENCY			
Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the provider. I understand that I am financially responsible for any balance. I also authorize **[practice name]** or insurance company to release any information required to process my claims.

Patient/Guardian signature

Date