INSURANCE FORM

This form is required for all clients who are covered by insurance, EAP, or managed care benefits.

1. Client's Name: ____
2. Name of Insured: ____
3. Insured's Employer (if group policy): ______________________________
4. Address of Employer: ____
5. Employee ID/SSN of Insured: ___________________________________
6. Relationship of Client to Insured: _________________________________
7. Check one of the following: ❑ Insurance ❑ Managed Care ❑ EAP
8. Managed Care/ Insurance Company:_______________________________

   Address: ____

   Telephone: __________________ Group Number: __________________
9. Is there another health benefit plan or insurance company providing coverage? ❑ Yes ❑ No

   If Yes, complete the following:

   Name of Insured: ____

   Other Insured's Policy or Group Number: ___________ Other Insured's D.O.B. ___________

   Other Insured's Employer: ____

   Other Insurance Plan Name: _______________________________________

RELEASE OF INFORMATION FOR CLAIM BENEFITS

I hereby authorize DCIC and any member of the clinical staff of the Center to provide summary of care and assessment information regarding evaluation and /or treatment of ___________________________ for the purpose of evaluating and processing claims for benefits.

Signed: _________________________________ Date signed: ___________________

Client or Parent/Legal Guardian

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