BCBS Insurance Information- BCBS Policyholders ONLY

INSURANCE DOES NOT GUARANTEE THAT ALL COSTS ARE COVERED. CLIENTS ARE RESPONSIBLE FOR PAYMENT OF ALL BALANCES, INCLUDING COPAYS, PAYMENT FOR UNMET DEDUCTIBLE, OR UNCOVERED SERVICES.

Client Name: ____ DOB: ________________________

Address: ____

City: _____________________________________ State:___________ Zip: __________________

Email: ________________________________

Sex (circle one): Male Female Other Social Security #: ________-_______-_________ (for insured only)

Home phone: __________________________________ Work phone: ___________________________

Check one: ( ) Single ( ) Married ( ) Divorced ( ) Widowed ( ) Student ( ) Child

GREY AREA ONLY IF NOT PRIMARY POLICY HOLDER

Responsible Party: ______________________________________ (“self” or other primary policy holder)

Relationship to client:______________________________________

Address: ____

City: __________________________State: _______________ Zip: _____________

Date of Birth: __________________ Social Security#: ____________________________

Employer: _____________________________ Work phone: _____________________________

Release to Insurance Company: *I request the payment of authorized benefits be made on my behalf to Brock Caffee, LCMFT for any services furnished by him. I further authorize Brock Caffee, LCMFT and his billing service, Hunter Billing Solutions, LLC, to release to my insurance company and its agents via direct mail, telephone, email, fax, or electronic submission, information about me and my treatment in order to determine the benefits payable for related services. I recognize that insurance benefits are limited, that I am financially responsible for non-covered expenses and that a psychological diagnosis must accompany requests for payable benefits. I also understand that additional information is often requested by insurance companies as claims are processed.*

***Signed:* ____ *Date:* ______________________**

Blue Cross/Blue Shield ID#:________________________________Group#:_______________________________

Insured name: ____DOB:___________________________

Did you contact your insurance company prior to today’s visit? Yes No (all session costs are client responsibility)

Do you have other insurance coverage? Yes No If So, what?__________________________________

Please provide copes of both sides of all insurance ID cards currently in force.