☐ No Change To Insurance Account #__________

Patient Name ______________________________ Soc. Sec. # ___________________DOB____________

Patient Address____
Street Address City State Zip Code

Patient Phone Number___________________ E-mail Address_______________________________________

PRIMARY INSURANCE INFORMATION

Cardholder's Name____

Cardholder's Phone Number (Home / Work / Other) ________________ / _________________ / ______________

Cardholder's Address:____

Cardholder's DOB: _______________________

Cardholder's Relationship to Patient ____

Insurance Company Name ____

Insurance ID# _____________________________ Group / MMIS# ______________________________

Termination Date of Last Insurance Plan____
Month/Year

SECONDARY INSURANCE INFORMATION

Cardholder's Name____

Cardholder's Address ____
Street Address City State Zip Code

Cardholder's Phone Number (Home / Work / Other) _________________ / _________________ / _____________

Cardholder's Address:____

Cardholder's DOB: _________________________

Cardholder's Relationship to Patient ____

Insurance Company Name ____

Insurance ID# _____________________________ Group / MMIS# ______________________________

I HEREBY AUTHORIZE CPG TO RELEASE TO MY INSURANCE COMPANY, ALL MEDICAL INFORMATION NECESSARY IN ORDER TO PROCESS MY MEDICAL CLAIMS. I REQUEST THAT PAYMENT OF AUTHORIZED BENEFITS BE MADE ON MY BEHALF & ASSIGN THE BENEIFTS PAYABLE FOR SERVICES RENDERED TO ME AND / OR MY DEPENDENTS TO **COMPREHENSIVE PSYCHIATRY GROUP, INC.** OR AUTHORIZE SUCH ORGANIZATION TO SUBMIT A CLIAM ON MY BEHALF.

____ _______________________________
Insured's Signature Date