Complementary Out of Network Billing, Form 1 of 2

In order to verify and/or submit billing through your Out of Network insurance benefits, health insurance companies require that we obtain **ALL** of the following information.

This information can be found on your insurance card:

Client's Legal Name:
Client's DOB:

Name of Health Insurance Company:
Provider Phone Number (listed on the back of the insurance card):
Client's Insurance ID #:
Insurance Group Number:

Place an 'X' by the client's relationship to the Insured?
SELF SPOUSE CHILD OTHER

Insured's Name:
Insured's DOB:
Insured's Address:
Insured's Home Phone:
Name of Insured's Employer:

Place an 'X' by the client's Employment Status?
EMPLOYED FULL TIME STUDENT PART TIME STUDENT

Place an 'X' by the client's Marital Status?
SINGLE MARRIED OTHER

Submit this form WITH the Authorization to Bill Insurance form.

You may hand hard copies of both forms to your therapist OR email both documents to our Billing Coordinator at Admin@FlourishCounseling.com.