Catholic Charities of the Diocese of Lexington

Insurance Form

This form needs to be completed by the **insured person** (because the counseling client might be a dependent) or the insured person's authorized representative. **Please call the insurance company prior to the first session** to see if pre-authorization is needed and to learn what mental and behavioral health services are covered. Please ask the insurance company for the information in the box below:

Authorization Number (if needed) :____
Effective Start Date:______________________ **Effective End Date:**_____________________
Number of Visits Covered: ________________________

Deductible:_______________________ **Visit Co-payment:**____________________________

Covered length of session (circle all that apply): 30 minutes 45 minutes 60 minutes

The following information is needed to create an insurance claim. Please fill in **all** spaces.
Name of Counseling Client____
Patient Relationship to Insured (Circle) Self Spouse Child Other
Name of Insurance ____
Insured's Member/Subscriber ID :____
Group Number:__________________________**Plan Name:**___________________________
Insured's Name: Last Name___________________ **First Name**____________ **MI**___
Insured's Date of Birth: ____
Insured's Address: Line 1____
Line 2____
City__________________________________ **State**_______ **Zip**_______
Insured's Phone Number (include area code)____
Is this the only insurance company? Y or N Is this the PRIMARY insurance? Y or N

I authorize payment of medical benefits to Catholic Charities of the Diocese of Lexington for mental health services.

____ ________________________
Insured or Authorized Person's Signature **Date**

If you have insurance coverage from more than one insurance company, please fill out a form for each company.

PLEASE ATTACH A COPY OF THE INSURANCE CARD, FRONT AND BACK.