

RESOLUTIONS THERAPY
INDIVIDUAL, COUPLE & FAMILY THERAPY

COORDINATION OF BENEFITS FOR INSURANCE COVERAGE

Primary Insurance Company Name: _____

If you have other insurance in addition to your primary coverage, we will need your other insurance information to send to your primary insurance company. By coordinating benefits among all insurance carriers, you will receive the maximum benefits available.

PATIENT Name of Patient: _____ *Date of Birth: _____

INSURED Name of Insured: _____ *Phone #: _____

Relationship to Patient: Self Spouse Parent Other _____

Group or Claim #: _____ Subscriber / Member #: _____

***Does the patient have other insurance or Medicare Coverage?**

YES Continue with form NO Go to the Name and DOB Section and skip all fields below.

SECONDARY INSURANCE CARRIER:

* Name of the Insured for the Secondary Insurance policy: _____

*Relationship to Patient: Self Spouse Parent Other _____

* Name of Secondary Insurance Carrier: _____

* Insurance Carrier Claim address: _____

*Carrier Phone # _____ *Subscriber / Member #: _____

*Group #: _____

Beginning date of Coverage: _____ End date of Coverage (if applicable): _____

Secondary insurance covers? Self Spouse Child Other _____

If the Patient has other coverage and is a child or dependent whose natural parents are divorced or not married and not living together. Please skip if not applicable

Name of Dependent(s): _____

Relationship of other insurance member to child: Parent Stepparent Legal Guardian

Other _____

Child resides with: Parent Stepparent Legal Guardian Other _____

Person(s) with legal custody: Parent Stepparent Legal Guardian Other _____

Is there a court decree that has assigned primary responsibility for health care coverage?

Yes No

Relationship of party with decreed responsibility: Parent Stepparent Legal Guardian

Other _____

Name of responsible party: _____

Address: _____

Name & Date of Birth of both parents:

Mother's Name _____ Date of Birth: _____

Father's Name _____ Date of Birth: _____

Signature of Patient or Legal Guardian: _____