TRICARE Insurance Information Form

Client's Name: _____ Social Security # _____

Date of Birth: _____ Gender: _____ Marital Status: _____

Address - Street: _____ City/Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Email Address: _____ Drivers License # _____

May we leave a medically related message at home? _____ at work? _____ on cell? _____

PERSON RESPONSIBLE FOR PAYING FOR CARE

Sponsor Name: _____ Sponsor SSN: _____

Sponsor Address: _____ Sponsor Phone #: _____

TRICARE Program: __ Prime __ Prime Remote __ Standard __ Extra __ Reserve Select

Deductible $: _____ Deductible Met (Yes/No): _____

Authorization Required ?: _____ Authorization #: _____

Primary Health Care Provider (name & phone #): _____

Permission to Consult with Primary Provider regarding your care __ Yes __ No (please check)

Referral of Primary Provider Required for TRICARE coverage? __ Yes __ No (please check)

Do you have a Secondary Insurance? ◯ Yes ◯ No

Verification of Insurance Coverage (please describe your mental health coverage- write on back if needed): _____
_____

I authorize the release of any medical or other information necessary to process claims to my insurance carrier. I also request payment of government benefits either to myself or to the party who accepts assignment: Dr. Sandra Heinsz. I authorize payment of medical benefits to Dr. Sandra Heinsz for services rendered by her and submitted to my insurance carrier.

***Signature/ Date:*_____**