PATIENT INFO NEEDED FOR BILLING FOR JENNIFER RAPANOS, LMSW

Patient Name: _____

Date of Birth: _____

SSN: _____

Address: _____

City, State, Zip: _____

Phone Number: _____

If client is a child:

Guarantor's name: _____

Address/Phone: _____

Date of Birth: _____

SSN: _____

Insurance information:

Must have a copy of insurance card (front and back).

Must have a copy of pre-authorization, if applicable.

Policy holder's name: _____

Date of birth: _____

SSN: _____

Address/Phone: _____

Relationship to patient: _____

Policy #: _____

Group #: _____

Employer: _____

I agree that Billing Solutions, Inc, is authorized to submit insurance claims and follow up on insurance payments on behalf of Jennifer Rapanos, LMSW.

Signature:_____ Date: _____