CANA

Center for Africans Now in America

Insurance Release Information — Form 5

Date: _____ Therapist: _____

Name-Client: _____ DOB: _____ DX Code: _____

Policy Holder-Primary Insurance

Primary Insurance Company: _____ Phone: _____

Insurance Claims Address: _____

Policy/ID: _____ Group Plan ID: _____

Name of Policyholder: _____ Relationship: _____

Address: _____

Social Security Number: _____ DOB: _____

Name of Employer: _____ Phone: _____

Address of Employer: _____

Secondary Insurance

Secondary Insurance Company: _____ Phone: _____

Insurance Claims Address: _____

Policy/ID: _____ Group Plan ID: _____

Name of Policyholder: _____ Relationship: _____

Address: _____

Social Security Number: _____ DOB: _____

Name of Employer: _____ Phone: _____

Address of Employer: _____

Responsible Party

Name : _____ Relationship: _____

Address: _____ Phone: _____

Assignment and Release

I, the undersigned, certify that I (or my dependent) have insurance coverage as noted above and assign directly to the healthcare provider listed at the top of this form all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the healthcare provider to release all necessary information to FACTS to secure the payment of benefits and to mail patient statements. I authorize the use of this signature on all insurance submissions.

_____ _____ _____

Responsible Party Signature | Relationship | Date

Deductibles: $_____ ***FOR OFFICE USE ONLY***	**Co-pay: $_____** **Sliding Fee: $ _____** **Number of visits: _____**	**MA/Insu #: _____** **From __/__/__ to __/__/___**