

INSURANCE INFORMATION

Please complete the top portion of this form and sign/date the bottom portion.
Please have your current Insurance card available as well.

Name of Patient: _____ Gender: _____

Address: _____

Client Contact #: _____

Social Security # (patient): _____ DOB: _____

Name of Policy Holder: _____

Policy Holder SSN #: _____ DOB: _____

Insurance Company: _____ Phone # _____

Policy # _____ Group # _____

Office Use only:

Provider(s): _____ CPT codes: _____

Initial DOS: _____

Additional Notes _____

Verficiation Notes:

Effective Date: _____

Copay/ Coinisuranse: _____

Ded.: _____

of visits: _____

Prior Auth. : _____

*Please list all persons authorized to handle account/ billing issues: _____

** I authorize Manna Treatment Center, LLC, and its designated employees, to release confidential information regarding my medical condition or treatment to my insurance company and/or managed care company in order to obtain payment/authorization.

Patient or Responsible Party: _____ Date: _____

For office use only please affix copy of insurance card here: _____