WOMEN'S & CHILDREN'S CENTER FOR MENTAL WELLNESS

PSYCHIATRY
7591 Fern Avenue, Suite 1705, Shreveport, LA, 71105
T (318) 550-3398 **F** (318) 550-3481

HEALTH INSURANCE INFORMATION

In order for any claims to be submitted to your health insurance company the following information must be completely filled out and a clear copy of the front and back sides of your insurance identification card(s) will be made at the clinic.

PRIMARY HEALTH INSURANCE

Primary Insurance Company: _____

Insurance Company Telephone: _____

Insurance Company Address: _____

City, State, ZIP: _____

Patient's Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other: _____

Patient ID: _____ Patient Birth Date: _____

Patient Insurance Group #: _____ Patient SSN: _____

*Subscriber on Policy: _____

Subscriber ID: _____ Subscriber Birth Date: _____

Subscriber Insurance Group #: _____ Subscriber SSN: _____

Subscriber Address: _____

**THE SUBSCRIBER IS THE INDIVIDUAL IN WHOSE NAME A CONTRACT IS ISSUED OR THE EMPLOYEE COVERED UNDER AN EMPLOYER'S GROUP HEALTH CONTRACT.*

SECONDARY HEALTH INSURANCE

Secondary Insurance Company: _____

Insurance Company Telephone: _____

Insurance Company Address: _____

City, State, ZIP: _____

Patient's Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other: _____

Patient ID: _____ Patient Birth Date: _____

Patient Insurance Group #: _____ Patient SSN: _____

*Subscriber on Policy: _____

Subscriber ID: _____ Subscriber Birth Date: _____

Subscriber Insurance Group #: _____ Subscriber SSN: _____

Subscriber Address: _____

**THE SUBSCRIBER IS THE INDIVIDUAL IN WHOSE NAME A CONTRACT IS ISSUED OR THE EMPLOYEE COVERED UNDER AN EMPLOYER'S GROUP HEALTH CONTRACT.*