## 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 <u>must</u> 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 CO EMPLOYEE COVERED UNDER AN EMPLOYER'S GROUP HEA	
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:	

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