

SUE MAYO, MA, MFT
CA Lic #LMFT 37211
ID Lic #LMFT 7673
Lafayette, CA & Meridian, ID
925 - 284 - 0699

INSURANCE INFORMATION FORM

Insured ID Number: _____ **Policy Group #:** _____

Insurance plan name (Blue Cross, Aetna, etc): _____

Insured's name: _____

Insured's address: _____

Street address

City / State

Zip code

Phone

Insured's date of birth: _____

Patient's name (if different): _____

Patient's address: _____

Street address

City / State

Zip code

Phone

Patient's date of birth: _____

Is there another health benefit plan? (yes or no): _____

I authorize the release of any medical or other information necessary to process health insurance claims. I authorize payment of medical benefits to the provider listed above.

Patient or Authorized Person's Signature

Date