LifeCare Financial / Insurance Information

Patients using insurance must fill out this form or services will not be provided or cash must be used

Patient Name: _____ Date: _____
Address: _____ Phone: _____ Date of Birth: _____
_____ Work/Cell Phone: _____
Email Address:_____

SSN: _____
DL#_____
Do you have health insurance coverage? Yes_____ No_____
Do you intend to use it to pay for services? Yes_____ No_____
If no, how do you intend to pay for services?
_____
_____

If yes, please complete the following:
Insurance Information:
Insurance Company: ___Aetna ___Cigna ___Wellcare ___BCBS___ Compsych or EAP

Member# _____ Enrollment/plan/group number:
_____

Effective date: _____ Deductible met for year? Yes_____ No_____
Do you have / know your co-pay amount? _____ (Please remit copayment to therapist)
Client's relationship to policyholder:
_____
Provider's
Address:_____
_____
Provider's Phone: _____

Pre-approval or pre-authorization required? Yes_____ No_____

Pre-approval for specific provider? Yes_____ No_____

Pre-approval authorization number: _____

Number/Type sessions pre-approved: _____

As a courtesy, Lifecare will file your insurance claims for you free of charge. **If your insurance company does not pay within 35 days from the date of filing, you will be responsible for the cost of the session(s).** If you choose to pay for your session(s) with cash, check, or credit card, we can provide an invoice with the proper information so that you can file your claim through the insurance company for reimbursement.

Filing insurance claims uses a diagnosis to determine benefits. This diagnosis will be recorded by your insurance company and be part of your permanent medical record that will follow you for life. Please consider this when choosing to use insurance to pay for your therapy.

If you have not met your deductible, Lifecare will charge you for the amount that the insurance company has credited toward that deductible.

We cannot file claims for last minute cancellations or no-shows. If you do not provide at least 24 hours notice prior to an appointment, you will be charged for the session that you missed.

Please provide credit card information for use if your deductible has not been met, or if the above happens.

CC Number:_____ Exp __/__ Sec. Code _____ Zip Code_____

I grant this agency permission to release any information obtained during assessments or treatment which is necessary to support insurance claims for my/our treatment. I also grant this agency permission to charge my credit card for no-show fees, unmet deductibles, or declined insurance payments. I understand that I am responsible for all charges/ fees, regardless of insurance coverage.

Patient's Printed Name: _____

Signature: _____ Date: _____