Tots To Teens Therapy Services, Inc.

ANTHEM BC/BS BILLING AUTHORZATION

Client Name: _____
(Last) (First) (Middle Initial)

Home Address: _____ Apt # _____

_____
City, State, Zip Code

Home Phone #: _____-_____-_____ Other Phone #: _____-_____-_____

Client's Date of Birth: _____/ _____/ _____
Month/Day/ Year

INSURANCE INFORMATION:

Subscriber's Name: _____Subscriber's DOB: ____ /____ /_____

Subscriber's Member #: _____ Group #:_____

Client's Relationship to Subscriber: _____

Phone # on back of card:_____

REFERRAL INFORMATION:

Referring Physician: _____ Physician Phone #:_____

Practice Name/Address: _____

AUTHORIZATION TO BILL INSURANCE:

Patient or Authorized person's signature: I understand that I am responsible for all services provided by Tots To Teens Therapy Services, Inc. I authorize Tots To Teens Therapy Services, Inc. to submit claims to Tricare Prime on my behalf. I authorize the release of any medical or other information necessary to process my claims.

Printed Name of Person Responsible for Account: _____

Signature _____ Date_____