611 Forest Avenue, Maysville, KY 41056
Phone: 606-564-4016 Fax: 606-564-8288
Email: info@comprehendinc.org
Emergency Toll-Free: 1-877-852-1523

Billing / Insurance Information

Primary Insurance

Client's Name: ______________________________

Client's Relationship to Insured:
(Self, Spouse, Child, Other) ______________

Insured's Name:
(if different from Client) ______________________________

Insured's Address: ______________________________

Insured's Date of Birth: ______________

Insurance Company Name / Plan: ______________________________

Insured's Employer: ______________________________

Group #: ______________ **Policy #:** ______________

Medicaid #: ______________ **Medicare#:** ______________

Is there other insurance coverage for which you qualify? o Yes o No

Secondary Insurance

Client's Name: ______________________________

Client's Relationship to Insured:
(Self, Spouse, Child, Other) ______________

Insured's Name:
(if different from Client) ______________________________

Insured's Address: ______________________________

Insured's Date of Birth: ______________

Insurance Company Name / Plan: ______________________________

Insured's Employer: ______________________________

Group #: ______________ **Policy #:** ______________

Medicaid #: ______________ **Medicare#:** ______________

Is there other insurance coverage for which you qualify? o Yes o No

******Authorization is repeated on "Receipt of Forms & Information"******

I authorize Comprehend, Inc. to release to my third party payor any medical or psychiatric information (including any documents or reports requested) that may be required to process my claim with my primary or secondary payor listed above.

I understand that my claims cannot be processed without this release. I further understand that I may be billed at a future date for any services not covered by my policy. I agree to pay for any services not covered by my policy, based on Comprehend's sliding fee scale.

I hereby authorize and instruct my insurance company to make any benefits payable to Comprehend, Inc.

______________________	______________	________	______________________	________
Signature of Client / Representative	Relationship to Client	Date	Staff Signature	Date