



VEEMAH Integrated Wellness and Consulting Services, LLC
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INSURANCE INFORMATION

This form is completed along with the consent for service form

Services provided by VEEMAH are billed to your child's insurance company. Please provide your child's insurance information below.

Name: _____ Date of birth: _____

Address: _____

Name of insurance company: _____

ID number: _____ Group number: _____

IF PRIVATE INSURANCE THROUGH PARENTS PLACE OF EMPLOYMENT

Full name of Insurer name: _____ Date of birth: _____

Address: _____

Child's name: _____ Date of birth: _____

Child's address: _____

Name of insurance company: _____

ID number: _____ Group number: _____

IF YOU HAVE NO INSURANCE AND NO OTHER SOURCE OF FUNDING, PLEASE ATTEST BELOW.

I, _____ of _____
Parent/guardian child's name

do solemnly swear that my child does not have insurance or any other source of funding to pay for therapy services with VEEMAH. If I do have insurance for my child in the future, I agree to provide that information to VEEMAH. I do attest that the above statement is true to the best of my ability.

Name of parent/guardian: _____

Signature: _____

Date: _____