Preliminary Health Insurance Information

We realize that with a patient in crisis with a severe illness, managing some of the details related to accessing care can be overwhelming. The following form has been designed to garner information you may have so that we can be as effective as possible at fully researching your healthcare benefit on your behalf.
You may not know all of the answers to the questions – and that is okay. Simply fill in what you can.

All fields marked with * are required fields.

Policy Holder's Name:*
(Please enter name as it appears on the policy-card)

Policy Holder's Email Address:*

Policy Holder's Phone Number:*

Policy Holder's Date of Birth:*
(MM/DD/YYYY)

Patient Information

Patient's Name:*
(Enter name as it appears on the policy-card)

Patient's Date of Birth:*
(MM/DD/YYYY)

Patient's SSN:*
(###-##-####)

*Patient Address:**

Insurance Information

Name of Primary Insurance Company:*

Phone Number for Provider Services:*
(###-###-####)

*Subscriber ID:**

Member Number (if different from Subscriber ID):

Group Number:

Dependent's ID Number (if listed on the card):

Behavioral Health Insurance Information
(Sometimes, behavioral health services are administered by companies different from primary medical health insurance entities)

Name of Behavioral Health Carrier:*

Phone Number of Behavioral Health Carrier:
(This field may be left blank)

Policy Holder's Employer:*

Plan Type:*

PPO
HMO
POS
Unknown
Other:

Insurance Card Image:

Completion
By submitting this form, you authorize Bright Heart Health to contact the insurance company indicated on this form in order to verify health benefit information for the purpose of obtaining services provided by Bright Heart Health for eating disorder treatment.

Signature:

Date Completed*: