

**Restoration Counseling Services  
Health Insurance Claim Form**

Insured's ID Number: \_\_\_\_\_ Plan Name: \_\_\_\_\_

Insurance contact information: \_\_\_\_\_

Medicare \_\_\_\_ Medicaid \_\_\_\_ Champus \_\_\_\_ Group Health Plan \_\_\_\_ Other \_\_\_\_

1. Patient's Name: \_\_\_\_\_ 2. Birth Date: \_\_\_\_\_

3. Patient's Address: \_\_\_\_\_

4. Insured's Name: \_\_\_\_\_ 5. Birth Date: \_\_\_\_\_

6. Insured's Address: \_\_\_\_\_

7. Insured's Employer's name or School Name: \_\_\_\_\_

8. Patient's Relationship to Insured: Self \_\_\_\_ Spouse \_\_\_\_ Child \_\_\_\_ Other \_\_\_\_

9. Patient Status: Single \_\_\_\_ Married \_\_\_\_ Employed \_\_\_\_ Full time student \_\_\_\_ Part time student \_\_\_\_

10. Patient's Employer's name or School name: \_\_\_\_\_

11. Is condition related to: Employment \_\_\_\_ Auto Accident \_\_\_\_ Other Accident \_\_\_\_ Location (state) \_\_\_\_

Insured's Signature: I authorize payment of medial benefits to the undersigned physician or supplier mental health services.

Signed: \_\_\_\_\_

Patient's Signature: I authorize the release of any medical or other information necessary to process medical insurance claims. I also request payment of government benefits either to myself or the the party who accepts assignment.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_