Restoration Counseling Services
Health Insurance Claim Form

Insured's ID Number: ________________________________ Plan Name: _________________________

Group # ____

Insurance contact information: ____

Medicare ____ Medicaid ____ 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 medical benefits to Dan Pippinger and/or Restoration Counseling 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: ____________________