

**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: _____