

EPHESIANS LIFE MINISTRIES
Insurance Information

Client name _____ Date of Birth _____ Soc. Sec. _____

Client Address _____

Client Phone Number _____ Insured's Phone Number _____

Name of Insured _____ Date of Birth _____ Soc. Sec. _____

Address of Insured _____

Employer of Insured _____ Insurance Carrier _____

Address of Insurance Carrier _____

Insured's Identification Number _____ Group Number _____

Relationship of Client to the Insured (Indicate one): Self _____ Spouse _____ Child _____ Other _____

Date of onset of this condition (required) Month _____ Year _____

Is condition related to: Employment? _____ Auto Accident? _____ Other Accident? _____

Client is: Male _____ Female _____ Single _____ Married _____ Employed _____ Student _____

I am aware that insurance coverage is never certain until the payment is actually received. I am responsible for the balance if denial of payment is made by the insurance carrier and for any portion of the annual deductible of the policy. I will pay the co-payment at the time of service. I also understand that I am financially responsible for all appointments, unless I give 24 hours cancellation notice. I (not the insurance company) will pay a penalty fee of \$75 for appointments canceled with less than twenty-four hour notice, unless there is an emergency.

I authorize the release of any medical, mental health or other information necessary to process claims and payment for medical benefits to the supplier of services

Signature _____ Date _____

To be completed by clinician:

Diagnostic code(s) _____

Clinician's name (print) _____

→ Fax this completed form to 888-244-4737 ←