ClearPath Psychiatry & Counseling

Insurance Information

Primary Insurance Company:
_____

Member ID / Policy Number: _____ Group Number:
_____

Policy Holder Name: _____ Policy Holder DOB:
_____

Patient's Relationship to Policy Holder: ☐ Self ☐ Spouse ☐ Child ☐ Other

Secondary Insurance Company (if applicable):
_____

Member ID / Policy Number: _____ Group Number:
_____

Patient/Guardian Signature: _____ Date:
_____