INSURANCE INFORMATION AND VERIFICATION FORM

1751 Oak Plains Road, Ashland City, TN 37015 Ph: (931) 362-4723 Fax: (931) 362-2816

Date:_______________

Please complete this form for EACH applicable insurance provider. Also please attach a copy of BOTH the front and back of EACH insurance card.

Name of Youth Being Referred:____

Date of Birth: ____________________ **SSN:**________________________________

Legal Guardian: ____

Phone Number(s): ____

Name of Insured Party: ____
(Name on Insurance Card / Subscriber's Name)

Insured DOB: ____________________ **Insured SSN:** ________________________

Insurance Carrier: ____
(TNCare, Amerigroup, Aetna, BCBS, Cigna, etc.)

Identification Number: ____

Group Number: ____

Subgroup Number: ____

Relationship to Youth: ____
(Parent, Grandparent, etc.)

Street Address:____

City:______________________ **State:**_________ **Zip Code:** ___________

Phone Number(s): ____

Phone Number Listed on Card for Providers to Call: ____________________

Address Listed on Card: ____

City:______________________ **State:**__________ **Zip Code:** ___________

We are currently not in network with Tricare and United Health Care Community Plan.

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