Marymargaret Parker, MA, LMFT
Marriage & Family Therapy, Christian Counseling
CA Liccense 50535 Provider No, 1942574637
24107 Del Monte Dr. Valencia, CA 91355
661.259.4620 818-271.739

If you need a Statement and Claim form for your Insurer, please sign and complete this form. This information will be used to complete your Universal Health Claim Form 1500.

INSURANCE INFORMATION

CONFIDENTIAL - PLEASE PRINT
PATIENT NAME (*LAST, FIRST, MIDDLE INITIAL*)_____

PATIENT ADDRESS (*NUMBER & STREET*)_____

APT._____CITY _____, ZIP_____

TELEPHONE (*CELL*) _____(*HOME*)_____

PATIENT DATE OF BIRTH _____ ___MALE ___FEMALE

INSURED'S NAME (*LAST NAME, FIRST NAME, MIDDLE INITIAL*)_____

INSURED'S ADDRESS(*NUMBER & STREET)*_____

APT._____CITY _____, ZIP_____

TELEPHONE (*CELL*) _____(*HOME*)_____

INSURED'S DATE OF BIRTH_____ ___MALE ___FEMALE

NAME OF GROUP HEALTH PLAN_____

INSURANCE PROGRAM OR POLICY NAME _____

INSURANCE GROUP HEALTH PLAN ID NUMBER_____

PATIENTS RELATIONSHIP TO INSURED - ___SELF ___SPOUSE ___CHILD ___OTHER

PATIENT STATUS- ___SINGLE, ___MARRIED, ___EMPLOYED, STUDENT___ PART TIME ___ FULL TIME

PATIENT'S CONDITION RELATED TO - ____EMPLOYMENT ____AUTO ACCIDENT ____OTHER ACCIDENT

OTHER INSUREDS NAME_____

IS THERE ANOTHER HEALTH BENEFIT PLAN - ___YES ___NO

_____ _____
SIGNATURE OF PATIENT SIGNATURE OF INSURED

_____
TODAY'S DATE

I AUTHORIZE THE RELEASE OF ANY MEDICAL OR OTHER INFORMATION NECESSARY TO PROCESS THIS CLAIM. I REQUEST PAYMENT OF GOVERNMENT BENEFITS EITHER TO MYSELF OR PARTY WHO ACCEPTS PAYMENT. I UNDERSTAND THAT PROVIDING CLAIM INFORMATION DOES NOT GUARANTEE OR ENSURE PAYMENT BY INSURER.

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