

Carruth Center, Inc



11001 Hammerly Blvd. Houston Texas 77043 713-935-9088 713-935-0654 (fax)

Application for Receipt of: Health Insurance Claim Forms
PLEASE PRINT CLEARLY

INSURANCE COMPANY NAME: _____

Effective Date (i.e. term of policy Jan 1 – Dec 31) _____

GROUP (or FECA) Number of the Policy: _____

Policy is held through (name of work place): _____

INFORMATION ABOUT THE PATIENT (the child/person receiving the service)

Patient ID Number: _____

Patient FULL/LEGAL NAME: _____

Patient Date of Birth: MONTH _____ DAY _____ YEAR _____

Patient Gender: MALE FEMALE

Patient's Address: _____

City: _____ State: _____ Zip Code: _____

Phone(s): _____

Patient Status: (A) single married other
(B) employed full-time student part-time student

Is the patient's condition related to:

- a. EMPLOYEMENT (current or previous) YES NO
b. AUTO ACCIDENT YES NO (State: ____)
c. OTHER ACCIDENT YES NO

INFORMATION ABOUT THE POLICY HOLDER (parent or otherwise)

Policy Holder's FULL/LEGAL NAME: _____

Holder's Date of Birth: MONTH _____ DAY _____ YEAR _____

Holder's Gender: MALE FEMALE

Patient's relationship to Holder: self spouse child other _____

Holder's Address: _____

City: _____ State: _____ Zip Code: _____

Phone(s): _____

Is there another health benefit plan? YES NO (if YES, speak with office staff)

PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE: I authorize the release of any medical or other information necessary to process this claim. I also request payment or government benefits either to myself or to the party who accepts assignment.

SIGNED: _____ DATED: _____

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INSURANCE AUTHORIZATION
FOR RELEASE OF INFORMATION

In order to process a claim for benefits, I authorize the Carruth Center, any clinician, or other therapeutic provider to release to my insurance carrier any information regarding my child's medical history, symptoms, treatment, examination results, or diagnosis. A photocopy of this authorization shall be considered as effective and valid as the original. The authorization shall be considered valid for the duration of the claim, but not to exceed one year from the date signed. I understand I have the right to receive a copy of the authorization. Termination of consent must be submitted in writing.

Child's/Patient's Name: _____

Date: _____

Authorized Signature: _____

Print Name Clearly: _____