

# Insurance Information/Authorization

Client Name: \_\_\_\_\_ Client # \_\_\_\_\_

I hereby authorize payment directly to the Elizabeth Layton Center, Inc., of insurance benefits payable under terms of my policy(ies). In addition, I authorize the release of any medical information necessary to process my insurance claim. I also request payment of government benefits, if any, to the Elizabeth Layton Center, Inc. A copy of this authorization shall be considered as effective and valid as the original.

If changing insurance coverage, please note the following information:

Name of Previous Insurance: \_\_\_\_\_ Coverage End Date: \_\_\_\_\_

## Primary Insurance Coverage: (Check One)

- |                                                             |                                   |
|-------------------------------------------------------------|-----------------------------------|
| <input type="checkbox"/> None                               | Policy Holder/Insured: _____      |
| <input type="checkbox"/> Medicaid (Medical Card)<br># _____ | Insurance Co. Name: _____         |
| <input type="checkbox"/> Medikan                            | Policy Holder's DOB: _____        |
| <input type="checkbox"/> Medicare                           | Policy Holder's SS# or ID#: _____ |
| <input type="checkbox"/> HealthWave 19                      | Group #: _____                    |
| <input type="checkbox"/> HealthWave 21                      | Policy Holder's Employer: _____   |
| <input type="checkbox"/> BC/BS of Kansas                    | Employer's Address: _____         |
| <input type="checkbox"/> Champus/Champva                    | Employer's Phone #: _____         |
| <input type="checkbox"/> Other                              | Effective Date of Coverage: _____ |

## Secondary Insurance Coverage: (Check One, if applicable)

- |                                                             |                                   |
|-------------------------------------------------------------|-----------------------------------|
| <input type="checkbox"/> None                               | Policy Holder/Insured: _____      |
| <input type="checkbox"/> Medicaid (Medical Card)<br># _____ | Insurance Co. Name: _____         |
| <input type="checkbox"/> Medikan                            | Policy Holder's DOB: _____        |
| <input type="checkbox"/> Medicare                           | Policy Holder's SS# or ID#: _____ |
| <input type="checkbox"/> HealthWave 19                      | Group #: _____                    |
| <input type="checkbox"/> HealthWave 21                      | Policy Holder's Employer: _____   |
| <input type="checkbox"/> BC/BS of Kansas                    | Employer's Address: _____         |
| <input type="checkbox"/> Champus/Champva                    | Employer's Phone #: _____         |
| <input type="checkbox"/> Other                              | Effective Date of Coverage: _____ |

Date: \_\_\_\_\_ Authorized Signature: \_\_\_\_\_

Please present your insurance card(s) to the receptionist.