Elizabeth Layton Center
Insurance Information/Authorization

Client Name: ______________________________ **Client #** ________________________

I hereby authorize payment directly to the Elizabeth Layton Center, Inc., of insurance benefits payable under the terms of my insurance policy(ies). In addition, I authorize the release of any medical information necessary to process my insurance claim(s). I also request payment of government benefits, if any, to the Elizabeth Layton Center, Inc.

I understand that if all program requirements are met by the provider and payment is not made by the Insurance Company(ies) listed below, I may be held responsible for the charges. A copy of this authorization shall be considered as effective and valid as the original.

Date: ________________ **Authorized Signature:** __________________________________

Primary Insurance Coverage:

☐ None

☐ Medicaid (Medical Card) ID #: ________________________

☐ Other ***(the following fields are required)***

Exact Name of Insurance Company:

____

Policy ID#: ______________________________________

Group #: ____

Coverage Effective Date: ___________________________

Policy Holder's Name: ________________________________

Policy Holder's D.O.B: _______________________________

Policy Holder's SS#: _________________________________

Policy Holder's Employer:

____

Union/ Local name or #_______________________________

Secondary Insurance Coverage:

☐ None

☐ Medicaid (Medical Card) ID #: ________________________

☐ Other ***(the following fields are required)***

Exact Name of Insurance Company:

____

Policy ID#: ______________________________________

Group #: ____

Coverage Effective Date: ___________________________

Policy Holder's Name: ________________________________

Policy Holder's D.O.B: _______________________________

Policy Holder's SS#: _________________________________

Policy Holder's Employer:

____

Union/Local name or #_______________________________

☐ **Change in Insurance:**

Name of Previous Insurance: ____ Coverage End Date: __________________