Health Insurance Authorization

Edie Dietzen, MA, MS, LMFT #LF 00002107

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Client Information

Name _____ Date of Birth _____ SS# __N/A_____

Address _____ _____ ____ _____
street city state zip

Phone: (____)_____ Sex: ☐ Male ☐ Female

Client Status: ☐ Single ☐ Married ☐ Other
☐ Employed ☐ Full-Time Student ☐ Part-time Student

Client's condition is related to: Yes No Employment Yes No Auto Accident Yes No Other Accident

Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured's Information ☐ Same as above (skip to Policy Information)

Name _____ Date of Birth _____ SS# __N/A_____

Address _____ _____ ____ _____
street city state zip

Phone: (____)_____ Sex: ☐ Male ☐ Female

Policy Information

Insured's ID Number _____ Insured Policy Group or FECA number _____

Employer's Name or School Name _____ (_____)____-_____
Phone # for Benefit Authorization

Insurance Plan Name or Program Name _____

Is there another Health Benefit Plan? Yes No

Other Insured's Name _____

Other Insured's Policy or Group Number _____

Other insured's Date of Birth _____ Sex: ☐ Male ☐ Female

Employer's Name or School Name _____

Insurance Plan Name or Program Name _____

Authorization for release of information:

I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment.

_____ _____
Signature Date

Authorization for payment of medical benefits:

I authorize payment of medical benefits to **Edie Dietzen**, MA, MS, LMFT.

_____ _____
Signature Date

NPI: SS# or EIN: LMFT License #LF00002107

50-minute Sessions: 90801 Assessment 90806 Individual 90847 Family

Date of current symptoms: _____ Date of Previous episodes: _____ (first date)

Date unable to work: _____ to _____ (in current occupation) Date hospitalized: _____ to _____

Insurance Company: Date of coverage _____ Contract year _____

_____ Deductible Has deductible been met? Yes No YTD _____

_____ Co-insurance Has co-insurance amount been met? Yes No YTD _____

Benefits: Within Network _____ # of Visits per _____ _____ Co-Pay

Out of Network _____ # of Visits per _____ _____ Co-Pay

Prior Authorization # _____

Date	Name	Comments
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____