TRACY L. MCCAFFERTY, LCSW
Licensed Clinical Social Worker
License # 149-007270
Psychotherapy Services
1955 Raymond Drive, Suite 108
NORTHBROOK, IL, 60062
847.476.1532

I Must Have All of the Following Information In Order to Submit Claims on Your Behalf to Your Insurance Company:

Name of Primary Insured_____________________________________ Date: _____

Address: ____________________________________ Phone(s) ____________________

____

____

DATE OF BIRTH ___________________AGE_____________

Employer____

Email:____

<u>If Patient is a Dependent and not the Primary insured Please Also Complete:</u>

Name____

DATE OF BIRTH _______________________AGE_________

Address of Patient (if different)____

Cell Phone____

Email: ____

INSURANCE INFORMATION(found on your insurance card)

Plan Name: ____

Group #: ____

Identification #: ____

Customer Service Phone: ____

<u>HELPFUL QUESTIONS TO ASK REGARDING YOUR INSURANCE BENEFITS:</u>

Co-pay______________% covered per session ____________________________________

Effective date of policy______________________________________

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Deductable ? Yes NO Month deductable begins_______ _Amt of deductable $__________

Has deductable been met_________________________

Is Preauthorization needed? Yes No

Who should I contact in case of emergency_______________________Phone_________

I hereby authorize the release of any medical information necessary to process this insurance claim to my health insurance for behavioral health treatment.

____Client Signature
Date