Child Insurance Information Form

**This information will remain confidential*

Person Completing this Form: ___________________________

Relationship to Child: ☐ Biological Parent ☐ Adoptive Parent ☐ Foster Parent
☐ Court Appointed Guardian

Child's Name ______________________________________ Phone Number (____)______________________

Address ____

City ___________________________ State _______________ Zip Code ____________________

Child's Social Security Number ______________________________ Date of Birth ______________________

Is this child currently in foster care? ☐ Yes ☐ No

If Yes, through which county: ________________________________

# of Exemptions:
Household: _____________ (If placed in Foster Care or Guardianship setting please write 1)

**Receptionist will make a copy of all insurance cards, custody, foster care or adoption documents, & Parent ID*

Insurance Company ___________________________________ Policy Number ______________________________________

Subscriber's Name ___________________________________ S.S# / Date of Birth ______________________________________

Secondary Insurance ___________________________________ Policy Number ______________________________________

Subscribers Name ___________________________________ Subscribers S.S # / Date of Birth ______________________________________

Child's parents are: ☐ Married ☐ Divorced ☐ Separated ☐ Never Married

LCCMH Form # 294
01/27/2020 LZ

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*If there are legal custody arrangements you will need to bring in custody paperwork.

Do parents currently live together? ☐ Yes ☐ No

Please fill out information for both parents- if you have questions regarding this please see receptionist

Responsible Party Contact Information:

_____________________________ _____________________ _____________________

Parent /Guardian Name S.S Number Date of Birth

(Please Check) ☐ Parent ☐ Adoptive Parent ☐ Foster Parent Other___________________

Phone : (____)___________________

____

Address (if different from child's address)

_____________________________ _______________ __________________

City State Zip Code

Responsible Party Contact Information:

_____________________________ _____________________ _________________

Parent / Guardian Name S.S Number Date of Birth

(Please Check) ☐Parent ☐ Adoptive Parent ☐ Foster Parent Other___________________

Phone: (___)___________________

☐The below information is the same as above.

____

Address (if different from child's address)

_____________________________ _______________ ___________________

City State Zip Code

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Insurance Authorization for current or future treatment. This authorization may be cancelled at any time upon my request.

I hereby authorize Community Mental Health to apply for benefits on my behalf for covered services rendered by them. I also request that all payments from the agreed third party be made directly to them. I hereby certify that all the information that I have provided to you (including income and insurance) is true to the best of my knowledge. I will report within 14 days of any changes in my income or insurance to the agency. I further authorize the release of any necessary information to the agreed third party for this or related claims. I understand that I will be responsible for any charges incurred by me that are not covered by my insurance up to my ability to pay. Refusal to provide this agency with financial and/or insurance information will result in charging the above mentioned consumer with the full cost of service.

____ ____________________

Parent or Guardian Signature Date