WELLHOME PSYCHOLOGY
Home- and Community-based Therapies

Financial & Clinical Eligibility Determination/ Insurance Authorization

- I authorize the release of any information and/or copies of medical records necessary to process these insurance claims including alcohol and drug abuse diagnos(es) and related information.
- I agree to permit a copy of this authorization to be used in place of the original. I also agree that WellHome Psychology may use this authorization as my SIGNATURE ON FILE for all third-party payment claims purposes.

Primary Insurance Company Name: _____

Policyholder's Name: _____ Client's Relationship to Policyholder: _____

Policyholder's Social Security #: ____-____-_____ DOB: _____

Insurance ID #: _____ Group #: _____

Policyholder's Employer : _____ Other Source of Income: _____

☐ Checked box indicates client has no other insurance. _____ (initials)

Secondary Insurance Company Name: _____

Policyholder's Name: _____ Client's Relationship to Policyholder: _____

Policyholder's Social Security #: ____-____-_____ DOB: _____

Insurance ID #: _____ Group #: _____

Policyholder's Employer : _____

☐ Checked box indicates client has no other insurance. _____ (initials)

Tri-Care Commercial Insurance, Anthem HIP and Commercial Insurance, MDWise HIP insurance, Cenpatico/MHS HIP and Medicare covers outpatient mental health/substance abuse services when the services are done by a clinician with a degree and licensure that meet each company's criteria.

____ (initials) I have been given the explanation of covered and non-covered services.

_____ _____
Responsible Party Name (Printed) Responsible Party Signature

_____ _____
Witness (Printed) Witness Signature