S.E.E.DS. of the Willistons Inc.

129A Hillside Avenue ● Williston Park, NY 11596 ● (516) 742-5243

PLEASE COMPLETE THE FOLLOWING INFORMATION IN FULL

INSURANCE INFORMATION:

Is the patient the Insurance Carrier? Yes☐ No ☐

Insured's Name:____

Insured's Identification Number: (include any prefix)______________________________________

Insured's Date of Birth:____

Relationship to Client:____

Employer Name:____

Street Address:____

Telephone No.:_______________________________Fax No.:____________________________

Name of Insurance Company:____

Address of Insurance Company:____

Telephone Number of Insurance Company:____

Is there a co-payment? ☐YES ☐NO How much? _______________

Is there a secondary insurance? ☐YES ☐NO

IS PRE-CERT NEEDED? ☐YES ☐NO

Have you checked with your insurance company concerning speech therapy being a covered service?

☐ YES ☐ NO

Who Did you speak to at the insurance company?____________________

Phone Number__________________ Email Address:___________________________

*Please complete the entire **top** portion of the attached insurance claim form.*

***SIGN** in boxes 12. and 13.*