Bowden & Associates
Psychological and Counseling Services LLC
365 Riffel Road, Suite B, Wooster Ohio
330-345-3461

Insurance Information/Authorization to Bill Third Party

(*Please allow us to copy your insurance card.)*

Did you obtain prior authorization/pre-certification?
_____ Yes _____ No _____ Not Required

Primary Insurance:_____

Subscriber's Name: _____

Subscriber's DOB: _____

Place of Employment: _____

Policy ID # _____ Group#_____

SSN of Subscriber: _____

Subscriber's Address if different from patient:

_____

Secondary Insurance:_____

Subscriber's Name: _____

Subscriber's DOB: _____

Place of Employment: _____

Policy ID # _____ Group# _____

SSN of Subscriber: _____

Subscriber's Address if different from patient:

_____

Authorization to Bill Third Party

I hereby request that Bowden & Associates LLC bill the charges for any eligible services for the above-named client to my insurance company. I also authorize the release of any medical/psychological information necessary to process claims to the plan administrator or authorized agent if applicable for the purpose of determining benefits payable in connection with my claims.

I further authorize my insurance company to reimburse Bowden & Associates LLC directly. I understand that if my insurance does not cover the billed services within 60 days, I am responsible for payment of such services. Any insurance payment received by me will be forwarded to Bowden & Associates LLC.

_____ _____
Signature of Subscriber Date

Revised 03/01/2022