Connecticut Institute of Behavioral Health Inc.
495 Gold Star Hwy Ste 220 Groton, CT 06340
(P) 860-326-5405 (f) 860-326-5571

Patient Insurance Update

Patient Name:_____DOB:_____

Bills should be sent to (if other than patient):

Name _____ Relationship to patient _____

Address _____

City_____ State_____ Zip Code _____

Email _____ Social Security # _____

Home Phone _____Cell Phone _____Work Phone _____

Primary Insurance Information

Subscriber's Name _____

Date of Birth _____ Social Security # _____

Patient's relationship to insured (circle one): Self Spouse Child Other _____

Insured's Employer _____ Effective Date: _____

Insurance Company _____ Insurance Company Phone _____

Insurance ID# _____ Group # _____

Secondary Insurance Information

Subscriber's Name _____

Date of Birth _____ Social Security # _____

Patient's relationship to insured (circle one): Self Spouse Child Other _____

Insured's Employer _____ Effective Date: _____

Insurance Company _____ Insurance Company Phone _____

Insurance ID# _____ Group # _____

I authorize my insurance company, including Medicare if I am a Medicare Beneficiary, to make payments to Connecticut Institute of Behavioral Health, Inc for services rendered to me or my dependent by Connecticut Institute of Behavioral Health, Inc. Should my insurance carrier deny Connecticut Institute of Behavioral Health, Inc payment, I understand that I am financially responsible for the charges.

Signed: _____ Date:_____

I authorize Connecticut Institute of Behavioral Health, Inc to release any and all of my records to my insurer, or any other third party payer, legally responsible for the payment of medical expenses. I certify that the information provided or to be provided by me is correct and complete to the best of my knowledge. It is my responsibility to update any and all personal, insurance and health information.

Signed: _____Date: _____