

Gabrielle Lawrence, Ph.D.

5040 E Shea Blvd. #268
Scottsdale, AZ 85254
480-607-5030
gabrl1@cox.net

INSURANCE ADDENDUM

Only to be used for AZ Foundation, Aetna, Beech Street, BCBS, or Humana/LifeSynch
Information must be filled out entirely before submissions are possible.

CLIENT NAME: _____

CLIENT ID#(from card): _____

CLIENT DATE OF BIRTH: _____

INSURANCE COMPANY INFORMATION: (please circle one)

AZ Foundation Aetna Beech Street BCBS Humana/LifeSynch

MEMBER'S NAME (if different from Client): _____

MEMBER'S DATE OF BIRTH: _____

MEMBER'S EMPLOYER: _____

INSURANCE GROUP/POLICY #: _____

INSURANCE PLAN NAME: _____

INSURANCE BILLING ADDRESS & PHONE#: _____

DEDUCTIBLE \$ _____ Has this been met? ____ yes ____ no

COPAY PER VISIT \$ _____ HOW MANY VISITS PER YEAR?: _____

AUTHORIZATION REQUIRED? ____ yes ____ no

IF YES, AUTHORIZATION # IS: _____

Authorization Effective Dates are: _____ to _____

Please provide copy of insurance card, both front and back.

- Client is liable for **full session charges** incurred if information on file is not correct, of if insurance company denies payment for any reason.
- Client **WILL** be required to pay full fee at time of session if no information is received.