Lutheran Family Service

If you plan to use insurance to cover your counseling with Lutheran Family Service, please provide the following information:

Client Information

Client's Name:

Client's Birth Date:

Client's Address:

Client's SS#:

Guarantor/Responsible Party

Client's Primary Mental Health Insurance

Insurance Company:

Member's Birth Date:

Member's Name:

Member's SS#:

Member's Employer:

Relation to Client:

Insurance ID# :

Member's Group # :

Insurance Billing Address:

Insurance Phone # :

Member's Address:

Member's Phone #:

Client's Secondary Mental Health Insurance

Insurance Company:

Member's Birth Date:

Member's Name:

Member's SS#:

Member's Employer :

Relation to Client:

Insurance ID# :

Member's Group # :

Insurance Billing Address:

Insurance Phone # :

Member's Address:

Member's Phone #:

Primary Insurance Benefits

(please circle appropriate response)

Have you called your insurance company to pre-authorize your treatment?	Yes	No
Is your LFS counselor a network provider with your insurance company?	Yes	No
If no, are out-of-network benefits available to you?	Yes	No
What is the amount of your co-payment for each session?	$	
What is the amount of your annual deductible?	$	
Has your deductible been met for this year?	Yes	No
Does your insurance require a physician's referral before beginning counseling?	Yes	No