PATIENT INTAKE FORM PROVIDER: ELIZABETH MCQUEEN LPC

TAX ID#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ NPI#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DATE:\_\_\_\_\_\_\_\_\_\_\_ PATIENT NAME:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ MALE\_\_ FEMALE\_\_ AGE\_\_\_\_\_

DATE OF BIRTH:\_\_\_\_\_\_\_\_\_\_\_\_\_\_ MARRIED\_\_ SINGLE\_\_ STUDENT\_\_ SS#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

HOME ADDRESS:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_CITY:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ GA ZIP;\_\_\_\_\_\_\_\_\_\_\_\_\_

HOME PHONE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_WORK:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_CELL:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

OTHER PHONE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_EMERGENCY CONTACT:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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OFFICE STAFF ONLY

INSURANCE CO: BC AETNA CIGNA HUMANA UBH PHCS VALUE OPTIONS MEDICARE MEDICAID

MEDICARE CMO:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ AMERIGROUP WELLCARE MAGELLAN CENPATICO TRICARE SOUTH

OTHER:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ADDRESS FOR CLAIMS:PO BOX\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_PAYER ID#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PROVIDERS CALL:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_MENTAL HEALTH CALL:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SPOKE TO:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DATE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_TIME:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_INTERNET\_\_\_\_\_\_

INSURED NAME: SELF \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB:\_\_\_\_\_\_ SS#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

INS ID #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_GROUP:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_EMPLOYER:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

EFFECTIVE DATE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_ VISITS/UNLIMITED:\_\_\_\_\_\_\_ COPAY:\_\_\_\_\_\_\_\_\_ CO-INS:\_\_\_\_% INS:\_\_\_%

DEDUCTIBLE:\_\_\_\_YES \_\_\_\_NO AMOUNT MET:\_\_\_\_\_\_\_\_ AUTHORIZATION \_\_\_\_YES \_\_\_\_NO

AUTHORIZATION#:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ AX DATES:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PROVIDER IN NETWORK?:\_\_\_\_\_\_\_\_\_ PCP REFERRAL REQ?:\_\_\_\_\_\_\_\_\_\_\_ PREEXISTING?:\_\_\_\_\_\_\_\_\_\_\_\_

SECONDARY INSURANCE?:\_\_\_\_\_\_\_\_\_\_\_\_\_\_ WITH:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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FOR EAP ONLY

INSURANCE COMPANY:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PHONE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

AUTHORIZATION #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ # OF VISITS:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

AX DATES:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ MAIL CLAIMS TO:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cpt code:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Diagnosis Code:\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_