PEDIATRIC
Feeding & Speech
SOLUTIONS

Insurance Information

Patient: (First) _____ (Last) _____ (MI) ___

Address: _____ Zip _____

(Parents) Email Address: _____

Home Phone: _____ Work Phone: _____

Cell (parent/caregiver): _____ Cell (parent/caregiver): _____

Date of Birth: _____

Primary Insurance: _____

ID Number: _____

Group Number: _____

Policy Holder: (First) _____ (Last) _____ (MI) _____

Address: _____ Zip _____

Phone: _____

Employer: _____

Policy Holder's Date of Birth: _____ Gender: _____

Relationship to Child: _____

Insurance Plan Name or Program Name: _____

Is there another Health Benefit Plan? Yes No If yes, please provide information:

Secondary Insurance Name: _____

Secondary Policy Holder Name:____ _____

Secondary Insurance Policy Number and Group Number : _____

PLEASE TURN OVER AND FILL OUT THE BACK

Referring Doctor: _____

Practice Name of Doctor: _____

Address/Phone of referring Doctor: _____

I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

_____ _____
Parent/ Guardian Date

I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

_____ _____
Parent/ Guardian Date

Patient's Name: _____

☐ I understand that if the feeding/ dysphagia evaluation ($250.00) and/or feeding/ dysphagia therapy ($120.00) is not a covered service or is not deemed medically necessary by my insurance company, I will be responsible for the payment in full.

☐ I understand that if the speech and language evaluation (approximately $190.00) and/or speech and language therapy ($110.00) is not a covered service or is not deemed medically necessary by my insurance company, I will be responsible for the payment in full.

Date: _____ Time: _____

_____ _____
Parent/Guardian Therapist

Rev. 1/2016