

FINANCIAL INFORMATION FORM (to be done at Intake)

Name: _____ SSN _____ Date: _____

Financial Eligibility:

Self Pay (1000): Effective Date: _____ Adjusted Fee Amount \$ _____

Sub. Abuse: 10300: Effective Date: _____ End Date: _____

Mental Health: 10400: Effective Date: _____ End Date: _____

DID: 10500: Effective Date: _____ End Date: _____

Insurance (3+ Index/Secondary Insurance (5 + Index)/Worker's Compensation (11 + index)

Insurance Name: _____ Index # _____

Effective Date: _____ Client's relationship to Subscriber: _____

Subscriber's Info: Name: _____ DOB: _____

Address: _____

City: _____ State: _____ Zip Code: _____

SSN: _____ Sex: M F

Employer Name: _____

Employer Address: _____

Group #: _____ Policy #: _____

SCL 2 (4000): Effective Date: _____ ID #: _____

PDS/SCL2 (4003): Effective Date: _____ ID #: _____

EVV (4006): Effective Date: _____ ID #: _____

MPW (4004): Effective Date: _____ ID #: _____

Medicaid: 6000 6100 6300 6400 6500 6700 Effective Date: _____ ID#: _____

SA Medicaid: 7000 7100 7300 7400 7500 7700 Effective Date: _____ ID#: _____

First Steps (8000): _____

Medicare (9000): Medicare # _____

Grants (10 + index): Index #: _____

Contracts (12 + index) Index #: _____

MA Case Mgmt. Child: 13000 13100 13300 13400 13500 13700

Effective Date: _____ ID #: _____

MA Case Mgmt. Adult: 14000 14100 14300 14400 14500 14700

Effective Date: _____ ID #: _____

Signature of Person Completing Form: _____

Date: _____