Deborah Lyman, LCSW

INSURANCE AUTHORIZATION

Name: _____ _____ _____
↳ (LAST) (FIRST) (MIDDLE INITIAL)

Home Phone: ( ) _____ May we leave a message? ☐ Yes ☐ No

Other Phone: ( ) _____ May we leave a message? ☐ Yes ☐ No

Mailing Address: _____ _____ _____
(STREET & NUMBER or P.O.) (CITY AND STATE) (ZIP CODE)

Email Address: _____

Birth Date: _____ / _____ / _____

*** PRIMARY** Insurance Company Name: _____

Policyholder Name (if different than client): _____

Policyholder Employer Name: _____ DOB: _____ / _____ / _____

Insurance Identification #: _____ Group #: _____

*** SECONDARY** Insurance Company Name: _____

Policyholder Name (if different than client): _____

Policyholder Employer Name: _____ DOB: _____ / _____ / _____

Insurance Identification #: _____ Group #: _____

Deborah Lyman, LCSW, has my permission to communicate with my insurance company and to provide information necessary for the purposes of obtaining authorization for services, provision of services and coordination of care. Deborah Lyman, LCSW, or the billing service contracted with Deborah Lyman, LCSW, has my permission to bill my insurance company and to provide necessary information for the purposes of obtaining authorization for services, benefits information and payment.

Signature: _____ Date: _____

NOTE:
Please make a copy of the front and back of your insurance card(s) and mail the images to Deborah Lyman at the address below.

BILLING OFFICE ONLY

Self Pay: _____ Please provide benefit quote: _____ Diagnoses: _____