

# Kuna Counseling Center

190 W. Main St., Kuna, Idaho 83634

(208) 922-9001

## Insurance/Medicaid Information Sheet

Client Name \_\_\_\_\_ Birth Date \_\_\_\_\_ Gender: MALE FEMALE  
MM DD YY (Circle One)

Client Address \_\_\_\_\_ Home Phone Number \_\_\_\_\_  
\_\_\_\_\_ Work Phone Number \_\_\_\_\_  
\_\_\_\_\_ Cell/Other Phone Number \_\_\_\_\_

Relationship to Insured: Self  Spouse  Child  Other  Client Status: PART A: Single  Married  Other   
PART B: Employed  Full-Time Student  Part-time Student

IS THE CLIENT'S CONDITION RELATED TO: EMPLOYMENT  YES  NO AUTO ACCIDENT  YES  NO  
OTHER ACCIDENT  YES  NO

Insured's Name \_\_\_\_\_ Birth Date \_\_\_\_\_ Gender: MALE FEMALE  
Please Print exactly as it appears on your Insurance Card MM DD YY (Circle One)

Insured's Address: \_\_\_\_\_ Home Phone Number \_\_\_\_\_  
(Only list if different from client) (Only list if different from client)  
\_\_\_\_\_ Work Phone Number \_\_\_\_\_

Primary Insurance: \_\_\_\_\_ Policy Number \_\_\_\_\_ Group Number \_\_\_\_\_

Secondary Insurance: \_\_\_\_\_ Policy Number \_\_\_\_\_ Group Number \_\_\_\_\_

Deductible \$ \_\_\_\_\_ Amount met \$ \_\_\_\_\_ Copay \$ \_\_\_\_\_ # of allowed visits \_\_\_\_\_

Social Security Number: \_\_\_\_\_ Place of Employment: \_\_\_\_\_

Authorization Number: \_\_\_\_\_ EAP: Yes No \_\_\_\_\_

Medicaid: Yes No If yes, list Medicaid Number \_\_\_\_\_  
(Circle One)

Healthy Connections Doctor: \_\_\_\_\_

How were you referred, or how did you hear about Kuna Counseling Center? \_\_\_\_\_

I, as a Client or Insured Family Member, give consent and acknowledgement that this and other client information will be released to Insurance Carriers or Medicaid Agencies that provide financial reimbursement for requested services at Kuna Counseling Center:

\_\_\_\_\_  
(Client) (Date)

\_\_\_\_\_  
(Insured Family Member) (Date)