(Please print clearly. Please complete all information so that your claim can be processed quickly and efficiently. Thank you!)

******Attach a copy of the Patient's Insurance ID Card (both sides required) ******

Clinician Name: _Kyra Grosman, PsyD_ ****1st Date of Service________________**

PATIENT INFORMATION:

****Patient Full Name**: ______________________________ Gender __M __ F

****Address**: ______________________________

Telephone: ______________ ****Date of Birth**: ______________ SSN: ______________

****Location where services rendered (Only required if more than one practice location)** ______________

INSURANCE INFORMATION:

****Primary Insurance** (Name/Telephone): ______________________________

****Primary Insurance ID #:** ______________ / Group # ______________

****Policy Holder's Name**:______________ Relationship to Patient: ______________

Policy Holder's SSN: ______________ ****Policy Holder's DOB**: ______________

Secondary Insurance (Name/Telephone):______________________________

Claim Address: ______________________________

Secondary Insurance Group # and ID #: ______________ / ______________

Policy Holder's Name:______________ Relationship to Patient: ______________

Policy Holder's SSN: ______________ Policy Holder's DOB: ______________

****Diagnosis**: Axis I ______________ Axis II ______________

Axis III ______________ Axis IV ______________ GAF _____

Pre-Certification: (If authorization was already acquired)

Authorization Number: ______________ CPT Code(s) Authorized: ______________

Sessions Authorized/Date Range of Authorization: ______________________________

****Check ALL Possible CPT Codes that may be used:**

90791		90846		96103		96152	
90834		90847		96116		Other ( )	
90837		90853		96118		Other ( )	
90839		96101		96120		Other ( )	

Notes:

** Complete all areas that are **bold** with double asterisk (**) next to it. **