



Restorative Counseling Services

**ENLIGHTEN.  
ENCOURAGE.  
EMPOWER.**

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To confirm insurance eligibility, your insurance information form should ask for:

Patient's name \_\_\_\_\_

Date of birth \_\_\_\_\_

Name of the primary  
insured \_\_\_\_\_

Social security number of primary insured \_\_\_\_\_

Home Address of insured \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Insurance carrier \_\_\_\_\_

ID number \_\_\_\_\_

Group number \_\_\_\_\_

Contact information for the insurance company including phone number, website  
and address for submitting claims \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Please check your insurance coverage carefully. *(Remember to check your deductibles and co-payments.)*