Torrey Hills Health

Insurance Form

Client's Last Name _____ First Name _____ MI _____ DOB _____

Primary Insurance Company _____

Primary Insurance Company Address _____

City _____ State _____ Zip Code _____

Policy Number _____ Group Number (If any) _____ **(Insured's)** SSN _____

Deductible amount if any/ deductible met _____ Type of deductible (co pay or init ial costs) _____ # of Sessions per year/ type of service _____

(Insured's) Last Name _____ First Name _____ Middle Initial _____ DOB _____

(Insured's) Employer _____

SECONDARY INSURANCE

Complete the fields below

Secondary Insurance Company _____

Secondary Insurance Company Address _____

City _____ State _____ Zip Code _____

Policy Number _____ Group Number (If any) _____

Deductible amount if any/ deductible met _____ Type of deductible (co pay or initial costs) _____ # of Sessions per year/ type of service _____

(Insured's) Last Name _____ Middle Initial _____ First Name _____ DOB _____

(Insured's) Employer _____