

INSURANCE AUTHORIZATION LOG

Client's name: _____

Date of birth: ____/____/____

Address: _____

Home phone: _____ Work phone: _____

Occupation: _____ Employer: _____

Health Insurance Carrier/Company

Name of company: _____

Phone: _____

Name of policyholder (if not the client): _____

Date of birth: _____

Policy #: _____

Certificate #: _____

Limits to mental health benefits: _____

Address to send claims: _____

Co-pay/co-insurance per session: \$ _____

Authorization Number	Start Date	End Date	Number of Sessions Authorized

Additional notes

Date:

Date:

Date:
