ICARD
PLLC

701 W. 7th Ave, Suite 130 Spokane, WA 99204
Tax ID: 91-2150878
Ph: (509) 838-3932 Fax: (509) 838-1163

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ACCOUNT INFORMATION--PRIMARY PRIVATE & SECONDARY FORM

Client's Name: ____
Last   First   Middle Initial

Address: ____
Street   City   State   Zip Code

Client's DOB: ____/____/_____   Gender____________

Phone: Home: (____) __________ Cell: (____) __________ Work: (____) __________

E-mail:____

Mother/Father/Other ______________ Name: ______________________

Phone:Home: (____) __________ Cell :(____) __________ Work: (____)__________

Mother/Father/Other ______________ Name: ______________________

Phone:Home: (_____) __________ Cell:(_____)__________ Work: (____)__________

Primary Insurance Information

Primary Cardholder/Subscriber Information:

Name: ______________________________ DOB: ___/____/____

Insurance ID/SSN Number/: ______________ Group/Program Number: __________

Subscriber's Employer: ____________________ Phone: (_____) ______________

You must call your insurance company and document coverage prior to your appointment time.

Date Called: ___/___/______ Time: _______am/pm

Name of Insurance Company you are calling: ________________________

Phone Number of Insurance Company: (______) ________________

Name of Person/Contact you spoke to: ____________________________

Questions to Ask:

1. Does my plan have benefits for mental health/psychological testing services? Yes__ No __
2. What is the effective date of my insurance?______________
3. Do I have a deductible? Yes___ No____ If yes, what is the remainder? _________
4. What does my plan cover for psychological testing services?
   50% _____60% _____ 70% _____ 80% _____ 90% _____ 100% _____ Other % _____
5. What does my plan cover for mental health services?
   50% _____60% _____ 70% _____ 80% _____ 90% _____ 100% _____ Other % _____
6. Do I have a co-payment? Yes____ No ____ If yes, what is the amount? _________
7. Do I need a referral from my primary care provider (PCP)? Yes____ No ____ If yes, please have your PCP fax a referral to us at (509) 838-1163
8. Do I need preauthorization for testing? Yes___ No ___ For mental health? Yes___ No ____
9. Treatment plan required? No___ Yes_____ After _____ visits.

Secondary Insurance Information--APPLE HEALTH

Primary Cardholder/Subscriber Information:

Name: ____ **DOB:** ___/____/____

Provider One Number_____________________WA______

Insurance Carrier: **Molina** **CHPW** **UHC Community Plan**

Amerigroup **Coordinated Care**

ID Number_____________________________

Other Private Secondary Insurance Information (If applicable)

Primary Cardholder/Subscriber Information:

Name: ____ **DOB:** ___/____/____

Insurance ID/SSN Number/: __________________ **Group/Program Number:** ____________

Subscriber's Employer: _________________________ **Phone:** (_____) __________________

You must call your insurance company and document coverage prior to your appointment time.

Date Called: ___/___/______ **Time:** ________am/pm

Name of Insurance Company you are calling: _______________________________

Phone Number of Insurance Company: (______) _____________________

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5. **Do I have a co-payment? Yes____ No ____ If yes, what is the amount? __________**