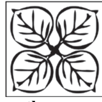

ICARD
PLLC
701 W. 7th Ave, Suite 130 Spokane, WA 99204
Tax ID: 91-2150878
Ph: (509) 838-3932 Fax: (509) 838-1163

Liz Pechous, PHD    Kristin Sims-Cutler, Ph.D., LMHC    Marie Pechous, MA, CCC-SLP

## ACCOUNT INFORMATION--PRIMARY PRIVATE & SECONDARY FORM

**Client's Name:** ____________________________________________
Last    First    Middle Initial

**Address:** ____________________________________________
Street    City    State    Zip Code

**Client's DOB:** _____/_____/______    **Sex:**______________

**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: (_______) ______________________**

**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 % _____**

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

**Rev 01/26/2023**