Watershed Wellness, LLC

1601 Milltown Road, STE 13
Wilmington, DE 19808

Email:watershedwellnessllc@gmail.com
Phone: (302) 476-0765

INSURANCE INFORMATION FORM

Client Name_____DOB_____

Home address_____City_____State_____Zip_____

Insurance Company_____Member ID#_____

Group#_____Member Services Phone #_____

Policy Holder Name_____DOB_____

Phone Number of Policy Holder _____Relationship to client_____

Address of Policy Holder: (if different than client address)_____

_____

AUTHORIZATION TO BILL INSURANCE: Patient or Authorized person's signature: I authorize Watershed Wellness, LLC to submit claims on my behalf. I authorize the release of any medical or other information necessary to process my claims.

Signed_____Date_____

I am aware it is my responsibility to provide up to date insurance information. If I fail to provide updated insurance information and claims are denied or adjusted, I understand I am responsible for payment in full.

Patient Initials _____