

To be completed by Responsible Party/Patient

List below all family members affected by this change of insurance that are seen at PRA!!

1. _____ 2. _____
patient first name last date of birth patient first name last date of birth

3. _____ 4. _____
patient first name last date of birth patient first name last date of birth

Check ALL clinicians affected by this insurance change & Effective Date of policy: _____ - _____ - _____

Perakis Resis Woods Paul Fabsik Womack Schoenbrod McFaul Godfrey Chang Olson

Therapist(s) List name(s): _____

Today's Date: _____ - _____ - _____ Relation to the Policy Holder: self spouse child other

Policy Holder's Name: _____ Policy Holder's D.O.B: _____ - _____ - _____

Policy Holder SS# _____ - _____ - _____ ***Must be completed!*** Group #: _____

Name of Insurance: _____ ID# _____ Insurance Phone #: _____

Policy Holder's Place of Employment: _____

Failure to complete ALL this information may result in insurance not being changed in our system timely, could result in services denied if precertification was not obtained prior to change of insurance and may result in full payment due by patient!