HUMANISTIC
COUNSELING CENTER

Humanistic Counseling Center
PO Box 24242
Cleveland, OH 44124
P: 216-839-2273
F: 216-896-0735

Insured Information Form Without Card

Please complete this form if your insurance card is unavailable.

Date_____ Therapist: _____

Client to Complete

Last Name_____ First Name_____ Middle Initial_____

Street Address_____City_____ State_____ Zip Code_____

Birth Date _____ Gender Identity/Administrative Identity _____/_____

SSN _____ Phone _____Email _____

Relationship to the insured: Self Spouse Child Other _____

Emergency Contact: Name _____ Phone _____

Subscriber Information

Last Name_____ First Name_____ Middle Initial_____

Birth Date _____ Gender Identity/Administrative Identity_____/_____

Street Address_____City_____ State___ Zip Code_____

SSN _____ Phone _____ Employer_____

Marital Status: Single Married Divorced Separated Widowed Student Status

PRIMARY INSURANCE COMPANY CARRIER

Policy # _____ Effective Date_____ Ins. Carrier Phone #_____

SECONDARY INSURANCE COMPANY CARRIER

Policy # _____ Effective Date_____ Ins. Carrier Phone # _____

Therapist Must Complete

Assigned Provider Code _____ Referral Source _____ Case Billing Code_____

LOCATION: AV ☐ BR ☐ BRU ☐ KT ☐ LY ☐ MH ☐ MN ☐ NOL ☐ PP ☐ RF ☐ RR ☐ ST ☐ WHts ☐ WI ☐ WP ☐

Diagnosis Code:

Office@HCCCares.com
www.HCCCares.com