

**\*\*Please Return to C.A.S.E., Inc. Office\*\***

**C.A.S.E., Inc.  
Insurance Questionnaire**

1) Name of patient/client: \_\_\_\_\_

2) Date of Birth: \_\_\_\_\_

3) Name of Insured: \_\_\_\_\_

4) Medical Insurance Company: \_\_\_\_\_

5) SSN of Patient/Client: \_\_\_\_\_

6) Home Address: \_\_\_\_\_

7) Home Phone Number: \_\_\_\_\_

8) SSN of Insured: \_\_\_\_\_

9) Insured's Employer: \_\_\_\_\_

10) Employer's Address: \_\_\_\_\_

11) Type of Coverage: PPO or HMO (circle one)

12) Co-pay: \_\_\_\_\_

13) Family Doctor: \_\_\_\_\_

Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_

14) Referring Physician: \_\_\_\_\_

Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Medications that your child is on: \_\_\_\_\_

15) Did you include a copy of your insurance card (front and Back)? Yes / No (circle one)  
We would be happy to make a copy of your insurance card in our office.

If you answered "No", please provide claim administrator address and group #.

Administrator Address: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Group #: \_\_\_\_\_

Subscriber/Member #: \_\_\_\_\_

\*\*Patient and/or Parent or Guardian is responsible for amount not covered by insurance.

Date: \_\_\_\_\_

Date: \_\_\_\_\_

\_\_\_\_\_  
Signature of Patient  
(If over 18 years of age)

\_\_\_\_\_  
Signature of Parent/Guardian  
(If patient under 18 years of age)

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**For Office Use:**

**Client referred to (circle all that apply):**

Friends' Club

Social Coaching

1:1 counseling

other: \_\_\_\_\_

**Start Date:**

\_\_\_\_\_

**Client's Supervisor:**

\_\_\_\_\_

**Notes:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_