Roanoke Valley Counseling Center, LLC
2727 Electric Road, Suite 103
Roanoke, VA 24018
(540) 355-8578

AUTHORIZATION TO BILL INSURANCE

I, _____ (client name), DOB_____, hereby authorize Roanoke Valley Counseling Center, LLC and it's providers to bill my insurance company/employee assistance program _____ for treatment.

My Subscriber/Member ID is _____.

My Group Number (if applicable) is _____.

The phone number to verify mental health benefits is _____.

Address: _____

(Street) (City) (VA) (Zip)

The primary subscriber (if not myself) is _____, DOB _____, whose address (if different from mine) is _____

_____ and who is employed by _____.

I understand that my diagnosis will be provided to my insurer. I understand that the insurance company may request additional clinical information regarding my treatment progress in order to authorize sessions and/or payment, and I authorize Roanoke Valley Counseling Center, LLC and its providers to provide such information as necessary.

_____ _____

Client or Guardian's Signature Date

_____

Print Name

For Internal Use Only

*Therapist Name:*_____

CPT Code _____

Dx _____

Dx _____

Dx _____

New Client ☐ *Insurance Change* ☐

Send to DMBS following first session or with new insurance cards.