UNIVERSITY of VIRGINIA
SCHOOL of EDUCATION and HUMAN DEVELOPMENT
Sheila C. Johnson Center

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1. Download form to your computer desktop.
2. Open form with Adobe Reader, available at https://acrobat.adobe.com/us/en/acrobat/pdf-reader.html
3. Save form after filling in the fields.
4. Return form via OnPatient

CLIENT AND INSURED (POLICY/ CARD HOLDER) INFORMATION

PLEASE FILL OUT THIS FORM COMPLETELY IN ORDER THAT WE MAY BILL YOUR INSURANCE COMPANY FOR YOUR SERVICES

CLIENT	POLICY/ CARD HOLDER
Name: _____	Name: _____
Address: _____	Address: _____
_____	_____
Date of Birth: _____	Date of Birth: _____

Client's relationship to policy/cardholder: ☐ Child ☐ Spouse ☐ Self ☐ Other: _____

Policy/Card Holder ID #: _____ Group #: _____

Medicaid/ Medicaid Managed Care #_____

POLICY/ CARD HOLDER SIGNATURE: _____ **DATE:** _____
(If Medicaid Guarantor Must Sign)

I request that payment of authorized Medicare and/or other health insurance benefits be made on my behalf to the University Of Virginia, Sheila C. Johnson Center (Center for Clinical I Psychology Service/ Speech-Language Hearing Center) for services furnished to me by their clinicians. I authorize the Sheila C. Johnson Center (Center for Clinical I Psychology Service/ Speech-Language Hearing Center) to release any information needed to determine these benefits or the benefits payable for related services to insurance carriers.

DO NOT COMPLETE IF WE HAVE A COPY (Front & Back) OF YOUR INSURANCE CARD

Insurance Company: _____

Insurance Company Provider Telephone Number (on back of insurance card): _____

Insurance Company Provider Address: _____

_____

PLEASE ALLOW US TO COPY YOUR INSURANCE CARD FOR OUR RECORDS

Revised 1/6/2023