

SCHOOL of EDUCATION and HUMAN DEVELOPMENT Sheila C. Johnson Center

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education.virginia.edu/research-initiatives/ sheila-c-johnson-center

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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:		
Client's relationship to policy/cardholder:	Child	Spouse	Self	Other:
Policy/Card Holder ID #:		Group #:		
Medicaid/ Medicaid Managed Care #				
POLICY/ CARD HOLDER SIGNATURE: (If Medicaid Guarantor Must Sign)		DATE:		
request that payment of authorized Medicare and/of Virginia, Sheila C. Johnson Center (Center for Clinifurnished to me by their clinicians. I authorize the Shanguage Hearing Center) to release any information services to insurance carriers.	ical I Psycholo neila C. Johnso	ngy Service/ Speed on Center (Center	ch-Language for Clinical I	e Hearing Center) for services Psychology Service/ Speech-
DO NOT COMPLETE IF WE HAVE	A COPY (Froi	nt & Back) OF Y0	OUR INSUR	RANCE CARD
nsurance Company:				
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