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/CARDHOLDER
Name: _____	Name: _____
Address: _____	Address: _____
_____	_____
Date of Birth: _____	Date of Birth: _____

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

Policy/Cardholder ID #: _____ Group #: _____

Medicaid/ Medicaid Managed Care #_____

POLICY/CARDHOLDER 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 for Clinical Services/Speech-Language Hearing, for services furnished to me by their clinicians. I authorize the Sheila C. Johnson 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 6/20/2024