Flatiron Mental Health Counseling

Please fill out the below form and email back to **fmhc.info@gmail.com**.

Insurance Verification Form

Name: _____ Date of Birth:_____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Email:_____

Insurance Carrier_____

Insurance ID #_____ Group Number _____

Are you the Primary Insured ? Yes_____ No_____

If not, name of Primary Insured:_____

Date of Birth of Primary Insured: _____

Address of Primary Insured: _____

Phone Number for Provider (this should be on the back of your insurance card): _____