PORTLAND DBT INSTITUTE, INC
5100 S MACADAM AVENUE, STE 350 PORTLAND, OREGON 97239
PHONE: (503) 231-7854 | FAX: (503) 231-8153

INSURANCE INFORMATION FORM

INSTRUCTIONS: Please fill out this form entirely so we can accurately bill your insurance. This may require a call to your insurance plan for help with obtaining your benefits information (look for a Member Services or Customer Service phone number on the back of your insurance card). Additionally, please **attach a copy of EACH insurance card (front and back)**, or ask our Front Desk to make a copy for you. Electronic insurance cards can be securely uploaded on our website here: www.pdbti.org/secure-upload/

Important Primary and Secondary Insurance Disclaimer: As a courtesy, we will bill your primary insurance for services rendered. You will be required to pay the balance remaining after your primary insurance has paid. If your provider(s) at PDBTI are in-network with your secondary and/or tertiary insurance plans, we will bill them as well and you will be required to pay any remaining patient balance. We will not bill secondary and/ or tertiary plans where we are out-of-network, however we will be happy to provide you with a statement should you wish to recover your out-of-pocket expenses directly from your insurance plan.

Client Name: _____ Client DOB: _____

[__] Check this box if you are UPDATING the existing insurance info. we have on file for the client!

PRIMARY INSURANCE INFORMATION

Subscriber's Name_____ Subscriber DOB_____
Subscriber SSN_____ Relationship to client_____
Subscriber Address_____City_____State____ Zip_____
Phone: _____ Subscriber's employer_____

Primary Insurance Company Name: _____
Effective Date of Policy_____
Identification #_____ **Group #**_____
Claims Address_____City_____State_____ Zip_____
Member Customer Service Phone_____ Provider Cust. Serv. Phone_____

Is pre-authorization required for services at PDBTI? ____ Yes ____ No
Name/phone number of contact for obtaining pre-authorization_____
Deductible amount(s) $_____ Deductible met as of today? ____ Yes ____ No
If deductible not met, how much left? $_____
Any limits to mental health benefit? ___Yes ___ No If Yes: _____ sessions per year / $_____ per year

Signature below of client/authorized person indicates: Portland DBT Institute (PDBTI) has my permission to bill my insurance company. I authorize PDBTI to release any information necessary to process my claims. I further authorize that my insurance benefits be paid directly to PDBTI. I understand that, additionally, the client will need to sign a Release of Information (ROI) form to consent to their records being shared with the insurance company to ensure compensation for services provided.

Printed Name:_____ Relation to Client:_____

Signature:_____ Date:_____

*(Please complete **other side** if you have additional insurance info!)*

INSURANCE INFORMATION FORM
(continued)

SECONDARY INSURANCE INFORMATION

Subscriber's Name_____ Subscriber DOB_____
Subscriber SSN_____ Relationship to client_____
Subscriber Address_____City_____State____ Zip_____
Phone: _____ Subscriber's employer_____

Secondary Insurance Company Name: _____
Effective Date of Policy_____
Identification #_____ **Group #**_____
Claims Address_____City_____State_____ Zip_____
Member Customer Service Phone_____ Provider Cust. Serv. Phone_____

Is pre-authorization required for services at PDBTI? ____ Yes ____ No
Name/phone number of contact for obtaining pre-authorization_____
Deductible amount(s) $_____ Deductible met as of today? ____ Yes ____ No
If deductible not met, how much left? $_____
Any limits to mental health benefit? ___Yes ___ No If Yes: _____ sessions per year / $_____ per year

TERTIARY INSURANCE INFORMATION

Subscriber's Name_____ Subscriber DOB_____
Subscriber SSN_____ Relationship to client_____
Subscriber Address_____City_____State____ Zip_____
Phone: _____ Subscriber's employer_____

Tertiary Insurance Company Name: _____
Effective Date of Policy_____
Identification #_____ **Group #**_____
Claims Address_____City_____State_____ Zip_____
Member Customer Service Phone_____ Provider Cust. Serv. Phone_____

Is pre-authorization required for services at PDBTI? ____ Yes ____ No
Name/phone number of contact for obtaining pre-authorization_____
Deductible amount(s) $_____ Deductible met as of today? ____ Yes ____ No
If deductible not met, how much left? $_____
Any limits to mental health benefit? ___Yes ___ No If Yes: _____ sessions per year / $_____ per year