Counseling, Mediation, and Educational Center, Inc.

Our mission is to provide counseling, mediation, and educational services to assist children and their families who are experiencing separation due to incarceration, juvenile delinquency, divorce, and various other family separations.

Date Completed: ______________________________
Client Name: ______________________________
If under 18 Parent Name: ______________________________

Basic Demographic info:
Date of Birth: ____________________ Social Security #:____________________
Address:____

Telephone: (H)_________________________ (C) _______________________

Insurance Information:
Is this Medicaid Insurance: ______YES ______ NO (If no skips this section and complete the section for Non-Medicaid Insurance)

Medicaid Insurance Plan: _______________ Medicaid Number: ____________________
Insurance Provider: ____________________ Insurance ID Number: __________________
Group #:__________________Provider Service # from back of card: ____________________

For Non-Medicaid Insurance:
Policy Holder Name:________________________Policy holder Date of Birth: _______________
Insurance Carrier:______________________Insurance ID:____________________
Group #:__________________Provider Service # from back of card: ____________________

The following will be completed by office staff:
Effective Date: ____________________

Benefit Year (calendar, fiscal, monthly):__________________to __________________

Co-Pay:____________Co-Ins: ____________________ Deductible: __________________

Out of Pocket Max per Year: Individual:________________Family: ____________________

Number of Office Visits Allowed Per Benefit Year:___________________

Number of Visits Remaining: __________________

Authorization Required: ______ Authorization#: ____

Effective/Expiration Date: _____________Number of sessions:________________

Verify where Mental Health Claims are sent: ______________________________

Address: ____

Date Verified:________________________Call reference number: _______________________