OUT-OF-NETWORK HEALTH INSURANCE CLAIM FORM

Pediatric Psychological Associates PLLC ("PPA")

PPA is providing this form to assist you in obtaining reimbursement from your Insurance Company for Out-of-Network Benefits. You should provide any other information required when submitting this form to your carrier. You should retain any receipts for payments you made.

PATIENT'S NAME Last, First, Middle Initial	PATIENT'S BIRTH DATE Month Day Year	SEX	INSURED'S NAME Last, First, Middle Initial
		☐ M ☐ F	

PATIENT'S ADDRESS Street Address City State Zip Code	PATIENT'S TELEPHONE
	( )

PARENT (Biological/Adoptive) Last, First, Middle Initial	PARENT SOCIAL SECURITY #	INSURED'S POLICY GROUP NUMBER
	- -	

INSURED'S ADDRESS Street Address City State Zip Code	INSURED'S TELEPHONE
	( )

INSURED'S BIRTH DATE Month Day Year	SEX	INSURED'S SOCIAL SECURITY #
	☐ M ☐ F	- -

AUTHORIZATION/REQUEST	INSURED'S STATEMENT
Patient or authorized person agrees to the release of this information and any additional information requested by insurance carrier. I also request payment of benefits to myself as the insured member and state that these services are not covered by any other health insurance.	In submitting this information I agree it is accurate and complete.
SIGNED	SIGNED

DATES OF SERVICE Month | Day | Year	DESCRIPTION OF SERVICES	CPT CODE	PAYMENT MADE TO PPA
1			$
2			$
3			$
4			$
5			$
6			$
7			$
			Total Paid $

PPA FEDERAL TAX ID #	PPA ADDRESS 9700 Park Plaza (106) Louisville, KY 40241	PPA CONTACTS kbrowning@kmhelpingkids.com / www.HelpingKidsReachHigher.com

TREATING DOCTOR SIGNATURE

I certify that the above services were necessary and provided to patient.

☐ PsyD

SIGNED ☐ PhD PRINT NAME