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Wellness based rehab for chronic conditions.
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INSURANCE AND RELEASE FORM

Please fill out the information below if you are a BlueCross Blue Shield policy holder. **PLEASE PRINT CLEARLY SO YOUR CLAIM CAN BE FILED ACCURATELY**.

Patient	**Insured**
Name - (Last, First, MI)	Name - (Last, First, MI)
Date of Birth	Date of Birth
Street Address	Street Address
City, State, Zip	City, State, Zip
Phone Number	Phone Number
Employer or School name	Employer or School name
Insurance Carrier Blue Cross Blue Shield	Insurance Carrier Blue Cross Blue Shield
Insurance Policy Number	Insurance Policy Number

Additional Questions

Is the patient's condition related to Employment? Yes___ No___ Auto Accident? Yes___ No___ Other Accident? Yes___ No___	Patient's relationship to the insured: Self ☐ Spouse ☐ Child ☐ Other ☐

Is Blue Cross Blue Shield your primary ☐ or secondary ☐ insurance plan?

Is there another benefit plan? Yes___ No___ If yes, complete the boxes below.

Name of Additional Insurance Carrier	Additional Insurance Policy Number

Medical Release - I give Integrative Wellness, Inc. permission to release and discuss protected health information with the following person(s) below:

Date	Name	Relationship
Date	Name	Relationship
Date	Name	Relationship
Date	Name	Relationship
Date	Name	Relationship

I authorized the release of medical information as indicated above and as necessary to process insurance claims.

Patient signature	Date