McLean HOSPITAL
HARVARD MEDICAL SCHOOL AFFILIATE

Neuropsychological and Psychological Testing Service
Patient Insurance Information Update Form

Please download this form before filling it out. Form can be completed by clinician or patient. Please return form via fax to **617.855.3246.**

Date: _____

Patient Information

McLean MR # (if applicable): _____

Patient Last Name: _____ First Name: _____

Patient DOB: _____ Age: _____ Gender: _____

Phone: _____ Email: _____

Address: _____

City: _____ State: _____ Zip: _____

Clinician Information

Referred by: _____ Referrer Phone: _____

Insurance Information

Primary Insurance: _____ Phone: _____

Insurance ID #: _____ Group # (if applicable): _____

Subscriber Name: _____ Subscriber DOB: _____

Secondary Insurance: _____ Phone: _____

Insurance ID #: _____ Group # (if applicable): _____

Subscriber Name: _____ Subscriber DOB: _____

For Office Use Only:

Form Originator: Dr. Schiller/Neuropsychology Fax: ext. 3246

This form should be faxed to the Patient Financial Service representatives at 617.855.3336. When insurance verification is complete, the remainder of the form will be filled out and faxed back to the originator.

Is pre-certification required? ☐ Y ☐ N Phone: _____

Information received: