Client Insurance Information

Client: ______________________________________ Date: ____________________________

AMHD Reference #: ________________________ Client Phone: ______________________

DOB: ____________________________ SSN: ___________________________________

Address: ________________________ _______________________ ________________
Street City Zip Code

Case Manager: ______________________________________ Phone: ________________

Diagnosis: Axis I :____

Does the client have medical insurance?

_______Yes (If yes, complete information below) _______No (If no, please apply client for Insurance benefits or explain in comments section below)

Insurance Coverage	Insurance Medical Number	Effective Date

Does client have DHS benefits?

______Yes (If yes, complete information below) _______No (If no, please apply client for DHS benefits or explain in comments section below)

DHS Unit/Worker: __________________________________ Phone: __________________________

Comments: ____

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