Counseling Covenant, LLC
P.O. Box 71155, Phoenix, AZ 85050
602-810-0933

Client Information

Name *(Last, First, MI)*

Street Address

City and State Zip Code

Telephone (Preferred)

Date of Birth MM DD YYYY

Gender M F

Social Security Number:

Employer Name or School Name

Insurance Company

Member ID (Subscriber) Group ID

Insurance Co. Telephone

Authorization Number:

Deductible Met? Yes NO

Amount Remaining $

Co-Insurance $ Co-Pay $

Relationship of Counselee to Policy Holder:
Self Spouse Child Other

Client is:
Employed FT Student Pt Student

Is issue related to employment? Yes No

Emergency Contact Phone Number Relationship

Secondary Insurance

Secondary Insurance Company

Policy Number

Group Number

Group Name

Telephone Number

Mailing Address for Claims

Mental Health Carrier *(If Different than above)*

Policy Number

Group Number

Telephone Number

Mailing Address for Claims

Policy Holder (If Other)

(Last, First, MI)

Address as Indicated on Policy:

City and State Zip Code

Telephone Number:

Policy Group

Date of Birth MM DD YYYY

Gender M F

Policy Holder's Employer's Name or School Name

Policy Holder's Social Security Number

Insurance Plan Name or Program Name

Is there another benefit plan? Yes No

If yes, complete blue middle section