



MARY ALICE  
FUHRER, LCSW

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### Insurance Verification

Client Name: \_\_\_\_\_ Client D.O.B. \_\_\_\_\_  
Name of Insured: \_\_\_\_\_ Insured D.O.B. \_\_\_\_\_  
Insured's Address: \_\_\_\_\_ Effective Date of Policy: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
Insured's Employer: \_\_\_\_\_  
Insured's SSN: \_\_\_\_\_

### Insurance Company's Information

Name: \_\_\_\_\_ Policy #: \_\_\_\_\_  
Address: \_\_\_\_\_ Group #: \_\_\_\_\_  
\_\_\_\_\_  
Deductible: \_\_\_\_\_  
Deductible met:  Yes  No  
Insurance Company's  
Phone Number: \_\_\_\_\_ Co-Pay:  Yes \$ \_\_\_\_\_  No

### Authorization to release information to insurance carrier

I authorize Mary Alice Fuhrer, MSW, LCSW, LLC to release any information necessary to the above named insurance carrier and benefits be made payable to Mary Alice Fuhrer, MSW, LCSW, LLC in my behalf.

Client's Signature: \_\_\_\_\_ Date: \_\_\_\_\_