



CHILDREN'S INSTITUTE
Research • Training • Treatment

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Insurance Information Form

PATIENT INFORMATION

Date: ____/____/____

Patient's Name: _____ DOB: ____/____/____ Gender: Female Male

Parent/Guardian Name: _____ DOB: ____/____/____ Relationship: _____

Street Address: _____ City: _____ State: ____ Zip: _____

Daytime Phone: _____ Alternate Phone: _____

Interpreter needed? Yes No Language: _____

REFERRING MD CONTACT INFORMATION

Referring MD: _____ Office Name: _____

Office Street Address: _____ City: _____ State: ____ Zip: _____

Phone: _____ Fax: _____

DIAGNOSIS

Diagnosis ICD-10 Code: _____

INSURANCE INFORMATION

Subscriber Name: _____ DOB: ____/____/____

Health Plan: _____ Authorization #: _____ Group #: _____ Member ID: _____

Secondary Insurance, if any: _____

ABA THERAPY • CHILD PSYCHOLOGY • SPEECH THERAPY • OCCUPATIONAL THERAPY • PHYSICAL THERAPY • AAC THERAPY
EARLY INTERVENTION • FEEDING THERAPY • LITERACY • SOCIAL SKILLS DEVELOPMENT • TELE THERAPY • TRANSITION TO ADULTHOOD

We Care More. We Do More.