

**INSURANCE INFORMATION**

**Primary Insurance:** \_\_\_\_\_ Member ID #: \_\_\_\_\_

Phone (of insurance company): \_\_\_\_\_

Name of Insured: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Phone: \_\_\_\_\_

Name of Employer: \_\_\_\_\_

**Secondary Insurance:** \_\_\_\_\_ MemberID #: \_\_\_\_\_

Phone (of insurance company): \_\_\_\_\_

Name of Insured: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Phone: \_\_\_\_\_

Name of Employer: \_\_\_\_\_

**Do you have a Health Spending Account?**  Yes  No

I, (print name) \_\_\_\_\_ authorize Bluegrass Nutrition Counseling to charge my HSA for qualified insurance expenses (i.e. copays, deductibles).

**Health Savings Account Info:**

Card # \_\_\_\_\_ Exp. Date \_\_\_\_\_ CVV: \_\_\_\_\_

Name (as printed on card): \_\_\_\_\_

Relationship to Client: \_\_\_\_\_

Billing Zip Code: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

(client or financially responsible party)