Date : _____

Please include a copy of BOTH the front and back of all insurance cards.
This information requested below is to verify insurance benefits.

(Print Legibly)
Name of Youth being referred:_____

Date of Birth:_____ SSN: _____

Legal Guardian: _____

Phone Number(s) :_____

Name of Insured Party: _____
(Name on Insurance Card / Subscriber's Name)

Insured DOB: _____ Insured SSN: _____

Insurance Carrier: _____
(Aetna, BCBS, Cigna, etc.)

Identification Number: _____

Group Number: _____

Subgroup Number: _____

Relationship to Youth: _____
(Parent, Grandparent, etc.)

Street Address: _____

City: _____ State: _____ Zipcode:_____

Phone Number(s) : _____

Phone Number Listed on Card for Providers to Call: _____

Address Listed on Card: _____

City: _____ State: _____ Zipcode: _____

www.cedargrove-rtc.com

CEDAR GROVE RESIDENTIAL TREATMENT CENTER
1640 Lascassas Highway Murfreesboro, Tennessee Zip Code 37130
Telephone 615-895-9590 *Facsimile* 615-895-9592