PLESHE COUNSELING SERVICES, LLC
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BUSINESS OFFICE
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THE FOLLOWING INFORMATION IS NEEDED FOR THE PROCESSING OF YOUR INSURANCE CLAIMS. **IT IS VERY IMPORTANT THAT IT IS COMPLETED THOROUGHLY.**

CLIENT NAME: _____ CLIENT DOB: _____

HOME ADDRESS: _____

ADDRESS CITY STATE ZIP

CLIENT'S HOME PHONE NUMBER: _____

CLIENT'S EMPLOYER: _____

INSURANCE COMPANY WE ARE FILING CLAIMS WITH: _____

POLICY HOLDER'S NAME (NAME OF INSURED): _____

POLICY HOLDER'S DOB (IF OTHER THAN CLIENT): _____

POLICY HOLDER'S ID # OR SS #: _____

GROUP NUMBER: _____

POLICY HOLDER'S EMPLOYER: _____