



INTAKE REQUEST FORM

Date of Request: ____/____/____

Client's Name: _____

Client's Date of Birth ____/____/____ Age: ____ Sex: __male __female __intersex

Gender: __male __female __nonbinary __other: _____

Home Address _____

City/Town _____ State _____ Zip _____

Is the client willing to attend? __yes __no __unsure

Referred by: _____ Phone: _____

Relationship to client: _____

Parent/Guardian Name: _____

Phone: _____ Email: _____

INSURANCE: __Aetna __Anthem/BCBS of _____ __Beacon __Cigna
__Harvard Pilgrim __United Healthcare __Health Plans __MassHealth (MBHP only)
__Oxford Health Plans __Tufts __Neighborhood Health Plans / Allways __Well Sense
__Unicare __Other: _____

PRIMARY INSURANCE ID # _____ **Group#** _____

Subscriber's Name _____

Subscriber's Birthdate ____/____/____ Insurance Phone: _____

SECONDARY INSURANCE ID # _____ **Group#** _____

Subscriber's Name _____

Subscriber's Birthdate ____/____/____ Insurance Phone: _____

Please Fax to 603-760-1949 or email to dave@endurancebehavioralhealth.com

