**Noah Roost, PhD**
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# Insurance Benefits Form

Please complete this form and email it to **Dr.Noah.Roost@gmail.com** as an attachment

| | | | |
|---|---|---|---|
| Patient's Name | | Date of Birth | |
| Phone Number | | Home Address City & Zip | |
| Primary Insurance Provider | | Insurance Phone | |
| Identification Number | | Group Number | |

Complete if you have Secondary Insurance:

| | | | |
|---|---|---|---|
| Secondary Insurance Provider | | Insurance Phone | |
| Identification Number | | Group Number | |

Complete if you are insured under someone else's policy (e.g. a spouse or parent). I will need the following information about your spouse or parent in order to access information about your insurance benefits.

| | | | |
|---|---|---|---|
| Primary Insured's Name | | Date of Birth | |
| Phone Number | | Home Address City & Zip | |