

Colette de Marneffe, Ph.D.  
8720 Georgia Avenue, Suite 205  
Silver Spring, MD 20910  
301-891-2120

**Tricare Insurance Form**

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ SSN: \_\_\_\_\_

Address: \_\_\_\_\_

Sponsor Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ SSN: \_\_\_\_\_

I, \_\_\_\_\_, authorize Dr. Colette de Marneffe to release to Tricare all treatment information necessary for insurance claim submission.

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