INSURANCE VERIFICATION FORM

Please fill out this insurance verification form in its entirety and bring it to your first therapy session along with a copy of your insurance card. This will make filing your insurance possible. Get an authorization number unless your plan states precertification is not required. Please print legibly!

INSURANCE INFORMATION:

Patient: ______________________ Birth Date: ______________

Patient SS#: ______________________

Patient Address: ______________________________________

____

Subscriber's Name: ______________________

Relationship to Patient: ______________________

INSURANCE COMPANY:

Name: ______________________

Policy/ID#: ______________________ Group ID#: ______________

Phone #: ______________________

Billing Address: ______________________

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MENTAL HEALTH BENEFITS:

Deductible $ ______________

Co-pay $ ______________

Visits Allowed Per Year __________ (Calendar Year Max)

Covered Therapies:

___ Individual

___ Marital/Family

___ Group

___ Psychological Testing

PRECERTIFICATION:

Precert Required: Yes or No

Visits Authorized _______

Start Date __________ End Date __________

Authorization # ______________________