INSURANCE VERIFICATION

Client's Name _____ Date of Birth _____

Insured: □ Self - if not SELF, insured's name _____ Are you: □ Spouse □ Dependent □ Other

Insured Employer _____

Employer Address _____

City/ST/Zip _____ Phone _____

IF YOUR INSURANCE REQUIRES: PLEASE PROVIDE AN INSURANCE FORM, SIGNED AND COMPLETED

INSURANCE INFORMATION:

Group # _____ ID # or SS# _____

Insurance Co _____

Mailing Address _____

City/ST/Zip _____ Phone _____

Insured's Date of Birth _____ : □ PPO? □ HMO? Authorization number _____

FOR MILITARY/CHAMPUS DEPENDENTS:

Military I.D. Card # _____ Issue Date _____

Sponsor's Name _____ Social Security # _____

Sponsor's Date of Birth _____Grade/Rank _____ Effective (on back of card) _____

Authorization number _____

Signature _____ Date _____

PLEASE REMEMBER TO SIGN AND DATE. STOP HERE

FOR OFFICE USE ONLY: 1st DOS: NOTES:

Dx # _____ Par Non-Par Date _____

Person contacted _____ Effective date _____

Deductible _____ End of year rollover ? □ Y □ N Deductible $ met _____

$ limitations ? _____ □Cal. year □ Fiscal year □ Lifetime

Max #/OV's _____ # used to date: _____ □ In network □ Out of network

Initial session paid _____ % $ ▪OV paid _____% $ ▪ Add'l time paid _____% $ ▪ Conjoint / family ok? □ Y □ N

Copay $ _____ Managed Care contractor _____

Is authorization required? □ Y □ N Obtained by: □ Provider □ Client □ Primary Care Physician

When needed? _____ Number to call _____

Authorization limits _____ Treatment reports required? □ Y □ N When? _____

Send to: _____

Original claim form needed? □ Y □ N Honor Assignment of Benefits □ Y □ N Codes required: □ CPT □ Other