

INSURANCE VERIFICATION

Client's Name _____

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:

Dx# _____ 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