INSURANCE INFORMATION AND VERIFICATION OF BENEFITS

Client Name_________________________________D.O.B.__________________

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Insurance Company____

Mental Health Outpatient Company (if different)_______________________________

Number to verify benefits__________________________

Information from:____________________________Date__________________

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Primary Insured_________________________

Policy #_______________________________

Group #______________________________

Primary Insured Birth Date____________________________

Primary Insured Address ____

Primary Insured Gender ________________

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Effective Date of Policy__________________

Max Payable Per Session________________ Dr Referral needed________

Percent Coverage______________________

Max Payable per calendar year____________ CPT Codes 90971__90834__90837__90847__90846__

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Number for Precert____________________

Precertification ID #_____________________

Certified by__________________________

Managed Care Company____

# of Sessions Authorized____________________

Patient Co-pay___________________________

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CLAIMS SENT TO;

Insurance Forms:

Company Forms___________

Standard CMS1500_______

Electronic Claims