INSURANCE VERIFICATION

Patient Name: _____ DOB: _____
Subscriber: Self Other: _____

Address: _____ phone: _____
Other contact info: _____
Insurance Company: _____
Group number: _____ Member ID number: _____ Is the person actively enrolled in the health plan and is there a disenrollment date? Yes No If yes, date:
Effective Date_____-

BEHAVIORAL HEALTH BENEFITS

Does the plan have an annual deductible? Yes No Amount: $_____ If so, how much of this deductible has been met to date? $_____

What is the maximum out of pocket expense? $_____ Is there a copayment amount? Yes No Amount: $_____

Is the reimbursement amount different for in-plan verses out-of-plan provider? Yes No _____ Is there any additional cost sharing between the health plan and the member/patient (ie percentage of the cost of service or set $$ amt)? Yes No Details: _____

Is pre-authorization required for Therapy? Yes No Are there limitations, exclusions, or restrictions on Behavioral Health Benefits? Yes No Dollar amount? _____ Specific Number of Visits? _____ Is the PT benefit shared with any other providers? Yes No

How much of the benefit is still available for the calendar year? _____, _____ Payor Contact Information:
Name/title: _____Phone/Fax: _____

How does subscriber secure claims form(s): _____

Address to send Claims: _____