Insurance Verification Form

Client: _____
Date of Birth:_____
Insurance Carrier/Plan:_____
Group Number:_____
Individual Number:_____

I do not currently take health insurance. However, I am often considered an <u>out-of-network</u> provider for most insurance plans. For those wishing to use out-of-network benefits, a receipt with all appropriate information necessary for reimbursement can be provided at the time of treatment. To learn more about your insurance benefits and reimbursement processes, please complete the following form in consultation with your insurance carrier.

PLEASE CALL YOUR INSURANCE COMPANY & OBTAIN THE FOLLOWING…

Benefits Contact Person:_____ Phone_____

Effective Date of Insurance Policy:_____

Does your policy cover mental health treatment (sometimes called Behavioral Health)?_____

What type of coverage? Outpatient( ) Group( ) Marital( ) Family( )

Is preauthorization necessary? Yes ( ) No ( )
If yes, please obtain the necessary forms.

Copayment Amount?:_____

Is there a deductible? No( ) Yes( ) If yes, $_____per year.
How much has been met to date? $_____

Coverage details:
_____% Covered in-network provider
_____% Covered out-of-network provider
_____# Sessions allowed per year

Used to date: $_____or _____# Sessions

Renewal date:_____

Is there a pre-existing clause to my plan?:_____