

PATIENT INSURANCE VERIFICATION OF BENEFITS FORM
(Please complete in full)

Name and address _____ DOB ____/____/_____

Soc. Sec.# _____
Home Phone _____
Cell Phone _____

Appointment date _____ Appointment time _____
Policyholder name _____ Policyholder DOB ____/____/_____
Policyholder Soc.Sec.# _____ Employer _____
Insurance Co. _____ Mental Health Phone # _____
Policy ID# _____ Group ID# _____ Eff. Date _____

Please contact your insurance company to answer the following questions:

Mental Health Claims address: _____

Do you have out patient mental health benefits? Yes or No
Is your doctor/provider in network? Yes or No
Do you have out of network benefits? Yes or No

Copay Amount \$ _____
Deductible amount \$ _____

Has it been met? Yes or No

Are authorizations required for a :

90801 (new patient) Yes or No
90805 (medication management/therapy) Yes or No
90862 (medication management) Yes or No

Authorization # _____

How many visits are approved # _____

Auth. Start Date: _____

Auth. End Date: _____

What type of insurance plan? HMO POS PPO EPO or Other

How many visits per year am I allowed? # _____

Plan's lifetime maximum benefit? _____

Patient Signature: _____ Rep. _____ Date: _____

We hope that this information will help you understand the mental health benefits of your insurance plan. Please arrive 30 minutes prior to your first appointment. Please understand that we do not accept financial responsibility for patients who see a provider who is not in network and/or benefits that are not covered under your insurance plan. Please note that missed appointments are not covered by your insurance plan.