Consult & Insurance Verification Form

Date Received:_____ Follow-up phone calls:_____

Client's Name: _____ DOB: _____

Parent/Guardian:_____

Contact Ph. #:_____ Text: YES or NO

Presenting Problem:_____

_____

REFERRED FROM:_____

****

Policy Holder's Name: _____ DOB: _____

Address:_____ Ph. #: _____

Primary Insurance Company: _____ Ph. #: _____

Member ID: _____ Group #: _____

Secondary Insurance Company:_____ Ph. #: _____

Member ID: _____ Group #: _____

Authorization Required:_____ Auth #: _____

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Out-of- Network (or) In-Network Benefits:

Type of Policy: Cal. Year (or) Contract Year _____ Effective Date: _____

Indiv. Ded. $ _____ Met: $ _____ Fam. Ded. $ _____ Met: $ _____

Insurance Covers _____ % with a _____ % co-insurance (or) $ _____ copay

Annual Max? _____ Lifetime Max? _____ Limit on VPY? _____

Out-of-Pocket-Max? $ _____ Met: $ _____

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Claims Address: _____

Verified By: ____ Date: _____ Ref #: _____ Rep's Name: _____

Authorization Info: _____

Other Info: _____

Scheduled intake:_____ Confirmed:_____