INSURANCE VERIFICATION FORM
FOR PROVIDER:

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PATIENT NAME:___________________________________DATE:__________________

DOB:____________________________SSN:________________________________

INSURED NAME:_________________________EMPLOYER:________________________

INS CO:_____________________________INS PHONE #:_______________________

ID/SUBSCRIBER#:____

IS MENTAL HEALTH COVERED? Yes__________ No_____________

IS MENTAL HEALTH COVERED THROUGH A THIRD PARTY?_______________

IF SO, WHO?____

IS THERE A PARITY/NON PARITY DISTINCTION: Yes__________No__________

DEDUCTIBLE AMOUNT___________________AMOUNT MET________________

INSURANCE PAYS__________________**CO-PAY:**__________________________

IN OR OUT OF NETWORK?____

IS AUTHORIZATION REQUIRED? Yes____________No__________

AUTH#:__________________________# OF SESSIONS;______________________

AUTHORIZATION DATE FROM:__________________TO:_________________