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Insurance Verification Information Sheet

To Be Completed if Insurance is to be Filed for Client

Patient Name: _____ Date of Birth: _____

Patient's relationship to Policy Holder: q Self q Spouse q Child q Other _____

Policy Holder Information: Insured's Name: _____

Gender: _____ Date of Birth: _____ Phone: _____ SS #: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Policy Information: Primary Insurance Company: _____

Plan Type: _____ Insurance Policy # ID: _____

Group #: _____ Employer of Insured: _____

Claims Address: _____

Secondary Insurance Co (if applicable) _____

Claims Address: _____

Please Contact Your Insurance Company to Provide the Following Information:

Authorization Begins: _____ Authorization Ends: _____

Authorization #: _____

# of Sessions Allowed:_____ Policy Deductible: _____ Deductible Met to Date: _____

Authorized Co-Pay Per Session / Co-Ins: _____ # Sessions a Year: _____
Calendar Year or Benefit Year (circle one)

Contact Person at Insurance Company _____ Phone # _____