BENEFIT VERIFICATION FORM

CLIENT INFORMATION

First name	Middle	Last	DOB	Sex

Street address	City	State	Zip

Home phone	Work phone	Cell phone
Leave message?	Leave message?	Leave message?

SEND BILLS TO (if other than client): **Name(s)** _____

Street address	City	State	Zip	Relationship to client

Best contact phone	Email (optional)	Fax (optional)

PRIMARY INSURANCE Company & Phone #: _____

Insurance Claims Mailing Address				
Name of Policy Holder	ID#	Group #		
Date of Birth	Relationship to Client	Sex	Policy Holder's Employer	
Policy Holder's address if different from client				

SECONDARY INSURANCE? ☐ **No /** ☐ **Yes** (See next page) Company: _____

OUTPATIENT MENTAL HEALTH BENEFITS Credentials: PhD

Date & Time Person talked to Effective date _____ Pre-existing: _____

Co-pay $_____ Co-Ins (client) _____% OOP Max $ _____

Deduct $_____ amt met $ _____ ☐ calendar year ☐ other

Pre-Auth ☐ N/☐ Y #_____ Session limits _____

☐ calendar year/ ☐ other: _____ to _____
Re-Auth/TX plan instructions:

Other:

Exclusions:

Covered CPTs: ☐ 90801 (dx interview) ☐ 90806 (indiv 45-50 min) ☐ 90846 (fam no client) ☐ (fam w/client)
☐ 90853 (group) ☐ 90862 (med) ☐ 96101 (psych test)

SECONDARY INSURANCE INFORMATION

Insurance Claims Mailing Address				
Name of Policy Holder	ID#	Group #		
Date of Birth	Relationship to Client		Sex	Policy Holder's Employer
Policy Holder's address if different from client				

OUTPATIENT MENTAL HEALTH BENEFITS Credentials: PhD

Date & Time Person talked to Effective date _____ Pre-existing: _____

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