MENTAL HEALTH INSURANCE VERIFICATION

Patient_____ DOB_____ Appt Date_____

Insured_____ Pt Phone H (____)_____ W (____)_____

Insured Employer_____ Relationship Self____ Spouse____ Child____

Cert/SS#_____ Group#_____ Policy#_____

Insurance Company_____ Ins Phone_____

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NON-PARITY BENEFITS

Maximum Visits_____ Effective Date_____

Insurance Pays_____ Copay/CoInsurance_____

Deductible_____ Met_____ OOP_____ Met_____

Pre-Existing_____ Limitations/Exclusions_____

Authorization Required Yes_____ No_____ Phone (____)_____

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PARITY BENEFITS

Maximum Visits_____ Effective Date_____

Insurance Pays_____ Copay/CoInsurance_____

Deductible_____ Met_____ OOP_____ Met_____

Pre-Existing_____ Limitations/Exclusions_____

Authorization Required Yes_____ No_____ Phone (____)_____

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SUBSTANCE ABUSE BENEFITS

Drug/Alcohol Related Yes____ No____ Max_____ Limitations_____

Insurance Pays_____ Copay/CoInsurance_____

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Spoke To_____ Verified By_____ Date_____

Claims Address_____ Attn_____

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