INSURANCE VERIFICATION FORM

☐ **No Insurance, going to be seen as Cash Pay**

Patient Information

Name_____DOB_____Gender____

Address_____

Cell #_____Home #_____Email_____

Subscriber Information- (if you are the subscriber of the ins policy then skip this section)

Name_____DOB_____Gender____

Address_____

Phone #_____Your relationship to Subscriber: Child/ Spouse?_____

Insurance Information

Primary Ins. Name_____HMO/PPO?_____

Primary Ins. ID #_____Group #_____Effective Date_____

Phone number on ins. card for Mental or Behavioral Health_____

Secondary Ins. Name_____HMO/PPO?_____

Secondary Ins. ID #_____Group #_____Effective Date_____

For Office Use only: Mental Health Benefits for Office visit with Psychiatrist(MD)

Benefits Managed By_____Accept Electronic claims?_____

Payor ID with Office Ally_____ CPT 90792, 99214, 99213, 90833, 90836 covered?___

Co-Pay_____Coinsurance_____Yearly Deductibles_____Deductibles Met___

Prior Authorization Required?_____ # of visits allowed per year_____

Timely Claim Filing Deadline/Limit_____

Ins. Rep/ Ref #_____Verified By _____Date_____