CBA Insurance Reimbursement Form for ABA Billing, LLC

Client's Information (the person receiving services):

Name: _____

Date of Birth_____ **Gender:** _____

Address: _____

City: _____**State:** _____**Zip:** _____

Home Phone Number: _____

Diagnosis: _____ **Social Security Number:** _____

Insured's Information (legally responsible party's information):

Insurance Company: _____

Identification Number: _____

Group/Plan Number: _____

Employer: _____

Insured's Name: _____ **Insured's date of Birth:** _____

Insured's Gender: __ **Insured's Email:** _____ **Social Security Number:** _____

Emergency Contact Information:

Name: _____

Relationship: _____

Address: _____

Telephone: _____

Do we have your authorization to contact this person concerning your medical services if the need arises?
___Yes ___No ___initial (patient or responsible party)

Consent and Release

I hereby consent to treatment by, and authorize insurance benefits to be paid directly to Clinical Behavior Analysis. I agree that I am responsible to pay, (1) for services not covered by my insurance company, (2) co-payments and deductibles, (3) any expense associated with the collection of a debt owed to them by me (i.e. attorney fee, court cost or collection agency fee) and (4) I agree that I have not other form of Insurance that covers ABA therapy services. I also consent to the release of pertinent medical information to my insurance carrier(s) for the purpose of processing health care claims.

Signature of Responsible Party: _____

Date: _____

Witness: _____

_____ (Phone Number)

Please list the telephone number specified on your insurance card above.

Please provide us with a copy of the front and back of your insurance identification card along with this form, if we do not have this information it'll cause delays.

To help you understand and verify your insurance coverage, please call your insurance plan and verify your benefits for ABA coverage. The number to call should be on the back of your insurance card.

Please call and ask your carrier:

Do you require a prescription?	Y ☐	N ☐
Do you have ABA coverage?	Y ☐	N ☐

What is the patient financial responsibility?	**In Network**	**Out of Network**
Co-Pay	$_____	$_____
Deductible	$_____	$_____
Co-Insurance	$_____	$_____

Annual maximum benefit	$_____	$_____
Lifetime maximum benefit	$_____	$_____
Maximum visits per year	_____	_____
Insurance Company	_____	
Pre-authorization required	☐ Y	☐ N
Representative's Name	_____	
Reference Number of call	_____	

Other information we need you to submit with this form:

1) A copy of the front and back of your insurance card ✖

2) Diagnostic Report ✖

3) Prescription for ABA Services ✖

If you have secondary insurance fill this section out completely, otherwise services may be denied:

Secondary Insured's Information (legally responsible party's information):

Insurance Company: _____

Identification Number: _____

Group/Plan Number: _____

Employer: _____

Insured's Name: _____ **Insured's date of Birth:** _____

Insured's Gender: __ **Insured's Email:** _____ **Social Security Number:** _____

If you do not have secondary insurance, check the box below after verifying.

☐ I do NOT have secondary insurance and verify that this is a correct statement.

Please call our intake coordinator if you have any questions or if you do not have any insurance coverage. We can help you explore additional funding sources. After we confirm your insurance coverage we will send you more information.

INTAKE COORDINATOR:

Kelly Fitzpatrick, ABA Program Coordinator,

Clinical Behavior Analysis

Contact: kfitzpatrick@abakentucky.com Phone: 502-409-7181

- **Insurance requires us to collect your Social Security number for verification and eligibility of benefits. Please provide and fax the form to 888-450-0935.**
- **Please submit the credit card authorization form with this form; this will only be used for your contracted co-pays & cost-shares according to your coverage, it is required to receive services.**
- **When the screening is scheduled, we will review your insurance or funding service verification, eligibility, ABA benefits, co-pays, deductibles, and cost shares based on your INS plan's information obtained from your insurance company.**

THANK YOU FOR FILLING OUT THIS FORM!

Questions Call – 502-409-7181

Have a great day.