

# Insurance Verification - Complete all – Insure your therapist is a provider.

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Insurance Company: \_\_\_\_\_

Address: \_\_\_\_\_

Claim Address: \_\_\_\_\_

Electronic Claim Address: \_\_\_\_\_

Phone# \_\_\_\_\_

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Client Name: \_\_\_\_\_

Subscribers Name: \_\_\_\_\_ Relation to client: \_\_\_\_\_

Insurance ID# \_\_\_\_\_ Group ID# \_\_\_\_\_

Employer \_\_\_\_\_

Client Phone Number: \_\_\_\_\_ Subscriber Phone # \_\_\_\_\_

Married \_\_\_ Single \_\_\_ Female \_\_\_ Male \_\_\_

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Name of referring Physician: \_\_\_\_\_ EIN# \_\_\_\_\_

Address of referring Physician: \_\_\_\_\_

Phone # \_\_\_\_\_ - Fax # \_\_\_\_\_

Initial Diagnosis of Referring Physician: \_\_\_\_\_

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If therapy is for accident: Employment \_\_\_ Auto \_\_\_ Other \_\_\_\_\_

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Prior therapy for same symptoms? Yes \_\_\_ No \_\_\_ Dates of therapy \_\_\_\_\_ to \_\_\_\_\_

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Insurance Company Contact Person name: \_\_\_\_\_

Date called \_\_\_\_\_

Preauthorization required? Y N Preauthorization # \_\_\_\_\_

Deductable (calendar or anniversary) Individual \_\_\_\_\_ Family \_\_\_\_\_

Deductable met? Y N Number of Sessions Covered \_\_\_\_\_

Percentages Paid? LPC covered? Y N OTR Due: \_\_\_\_\_

90801 Allow: \_\_\_\_\_ Copay: \_\_\_\_\_ Max visits per day \_\_\_\_\_

90806 Allow: \_\_\_\_\_ Copay: \_\_\_\_\_ Max visits per year \_\_\_\_\_

90808 Allow: \_\_\_\_\_ Copay: \_\_\_\_\_ Waiting Period \_\_\_\_\_

90846 Allow: \_\_\_\_\_ Copay: \_\_\_\_\_ Pre-Existing clause \_\_\_\_\_

90847 Allow: \_\_\_\_\_ Copay: \_\_\_\_\_ VERIFIED BY \_\_\_\_\_

90853 Allow: \_\_\_\_\_ Copay: \_\_\_\_\_ VERIFIED DATE \_\_\_\_\_

COPY OF CARD Yes \_\_\_ No \_\_\_