Insurance Verification/Precertification Information

Primary/Secondary

Ins. Co: _____ Phone: _____
Managed Care Co: _____ Phone: _____
Insured: _____D.O.B.:_____ SS/ID#: _____
Patient:_____ SS/ID#: _____
Diagnosis: _____ D.O.B.:
Policy#: _____ Group #: _____
Employers Name: _____

Description of Outpatient Nervous and Mental Benefits

Effective Date: _____
In Network? Yes/No, Precertification needed?_____
Deductible: _____ Deductible Met? _____
Copay/Benefits:
Visit limits: Per Week _____ Per Year _____ Life _____
Dollar limits: Per Week _____ Per Year _____ Life _____
Family Therapy: _____ Group Therapy: _____
Testing:
Specific Coverage Limits: Are any diagnoses excluded?_____
Is there a pre-existing condition clause? Yes / No, If yes, what is the exclusion_____

Covered Providers: M.D. ___ Ph.D. ___ L.C.S.W. ___ L.P.C. ___ R.N., C.N.S.

Mail Claims To:
_____
_____
_____

Electronic Claims Payor ID #:

Electronic Claims Address:

Verified by: _____ Spoke With: _____ Date:

Appt Date and Time _____ Therapist: _____