

**INSURANCE VERIFICATION FORM**

**APPOINTMENT DATE:** \_\_\_\_\_

**PSYCHOLOGIST:** \_\_\_\_\_

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

SSN: \_\_\_\_\_

Insurance Co.: \_\_\_\_\_ Phone #: \_\_\_\_\_

Policy Holder: \_\_\_\_\_

Employer/Insured: \_\_\_\_\_ ID #: \_\_\_\_\_

Group #: \_\_\_\_\_

Diagnosis/Reason for Visit:  
\_\_\_\_\_

**BENEFITS: (Please call your insurance company to obtain the following information)**

What is my effective date? \_\_\_\_\_

What is my copayment amount? \_\_\_\_\_

Do I have a deductible? Yes No If yes, What is my deductible? \_\_\_\_\_

Has it been met this year? Yes No

What percentage of the charges does my plan pay? \_\_\_\_\_

Are the benefits different for a serious mental illness? Yes No If yes, what is the benefit?

\_\_\_\_\_

Is there a limit to the number of visits per year? Yes No If yes, what is the limit? \_\_\_\_\_

Is there a Pre-existing clause to my plan? Yes No

Is Pre-Authorization required? Yes No

Referral / Authorization #: \_\_\_\_\_ # Visits: \_\_\_\_\_ Effective dates:

\_\_\_\_\_

Spoke to: \_\_\_\_\_