Insurance Verification

Name: ______________________________ Date: ____________

S.S. #: ______________ D.O.B: ______________ Group # ______________

Effective Date:__________ In network: ________ Which Network: ____________

Pre-certification required: ________ Phone #: ____________ S/W ____________

Send claims to:

____

____

____

Authorization #:____

Start date: ________________ Ending date: ________________

Number of Sessions: ____________

Deductible: ________________ Co-Pay: ____________________

Out of Pocket: ________________ Out of Pocket Limit: ________________

CPT Codes Covered/Reasonable & Customary Fee for Service:

________ 90801 Diagnostic Evaluation

________ 09806 Individual Psychotherapy

________ 09844 Individual Psychotherapy

________ 09847 Family Therapy

________ 90853 Group Counseling

________ Other

Covered Credentials: ____________

Required: ________________ Exceptions: ____________________

Are there any substance abuse benefits?: __________

Out of network benefits:

Deductible ______________ Co-pay __________ Credentials ________

Out of Pocket ____________ Out of Pocket limit ________________

Authorization # ____

Start date ____________________ End date ____________________

Number of Sessions__________