Insurance Verification Form

Patient name _____ Date of birth _____

Name of policyholder _____ Date of birth _____

Policyholder address _____

Policy ID _____ Group number _____

Insurance carrier _____ / phone number _____

Mental health carrier _____ / phone number _____

Mental health claims address _____

Electronic Payor ID _____

Name of representative confirming insurance/benefits _____

BENEFITS

In-network benefits Yes ☐ No ☐ Copay/coinsurance amount $_____

Effective date of insurance _____

Deductible amount $_____ Deductible met? Yes ☐ No ☐ N/A ☐

Authorization required? Yes ☐ No ☐

Is testing a covered benefit? Yes ☐ No ☐ _____

Number of visits allowed _____

Procedure code approved 96101/96118 ☒ _____

Verification date _____

Employee initials _____

Notes: