Everydaycounts-aba.com
(225) 588-3765

Insurance Verification Form

(Please print)

Today's Date: _____ Diagnosis: _____Physician Ordering ABA: _____

Client Information			
Client Name:	First:	Middle:	Last:
DOB:	Age:	❑ Male ❑ Female	Social security number:
Street Address:	Apt #:	City:	Zip Code:
Parent's First & Last Name:	Parent's Email Address:	Home phone:	Cell phone:
Insurance Information			
Person Financially Responsible:	Contact number:	Address (if different):	
Name on Policy:	Policy holder DOB:	Insurance Carrier:	Cell phone: Home phone:
Employer of insurance plan:	Insurance phone:	Coverage effective date:	Authorization phone:
Relationship to client: ❑ Self ❑ Parent ❑ Other	Member Number:	Group Number:	Policy Number:

I authorize the release of benefit coverage, payment information, and any necessary confidential medical information to be given to the provider. I authorize my benefit payments to be paid directly to the provider. I understand that I am financially responsible for any balance. I authorize Every Day Counts to be given any necessary information required to process my claims.

Policy Holder Name (Print) _____

Policy Holder Name (Sign) _____Date:_____

Return this form with a copy of the front and back of the insurance card, diagnosis of ABA, and any relevant evaluations.