Office:(763) 202-4767 Cell: (763) 228-8086
fax: 763-355-5718 info@veemahconsulting.com

School Therapy Insurance Information Form

School Therapy Services provided by VEEMAH are billed directly to each child's insurance company for each session they attend. Please complete the information below to help us process the billing accurately. We encourage you to contact your insurance provider directly about out-of-pocket costs.

STUDENT INFO: Full Name: _____Date of Birth: _____ Gender: _____

Address: _____School: _____

Please complete this section if your child is covered under government insurance (e.g., Medical Assistance, MinnesotaCare, PMAP, or MNsure)

Insurance Company Name: _____PMI Number: _____

Member ID Number: _____Group Number: _____

Please complete this section if your child is covered under a parent/guardian's private insurance (e.g., through parental employment)

Name of Insured Adult (*Required to bill private insurance*): _____

Date of Birth Insured Adult *(Required to bill private insurance):* _____

Address: _____

Phone: _____ Insurance Company Name: _____

Member ID Number: _____Group Number: _____

If your child is not currently covered by any insurance or funding source, please complete the statement below:

I, _____, parent/guardian of _____, do solemnly affirm that my child currently does **not** have health insurance or any other funding source to pay for therapy services provided by VEEMAH. I agree to inform VEEMAH if insurance coverage becomes available in the future. I attest that the information provided is accurate to the best of my knowledge.

PRINTED NAME of Parent/Guardian: _____

SIGNATURE of Parent/Guadian: _____ Date: _____