|  |  |
| --- | --- |
| **PATIENT INFO** | |
| Full Name: |  |
| DOB: |  |
| Requested Service | ABA |
| Service Location: (Home, Office, School, Community Center) |  |
| CPT:  Diagnosis: |  |
| Referring Provider Name & NPI  Service Provider Name: |  |
|  |  |
| **PRIMARY INSURANCE INFO** | |
| Insurance Name |  |
| Policy Number: |  |
| Group Number: |  |
| Insured Name: |  |
| Insured DOB: |  |
| Relationship To Client: |  |
| Home Address:  Phone Number: |  |
| **SECONDARY INSURANCE INFO** | |
| Insurance Name: |  |
| Policy Number: |  |
| Group Number: |  |
| Insured Name: |  |
| Insured DOB: |  |
| Relationship To Client: |  |
| Home Address:  Phone Number: |  |

Note:

1. We require front and back copies of insurance ID cards (both primary and secondary)
2. In addition to benefit information, is there anything else you want us to verify. If so, please be specific in the request

|  |  |
| --- | --- |
| Financially Responsible Name: | Phone Number: |
| Address: | |

I certify I am the parent/legal guardian of this child and am legally authorized to release this information on behalf of the policyholder and client. (Please check yes or no).

|  |  |
| --- | --- |
| Yes | No |

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize “**Your Company Name”** or the insurance company to release any information required to process my claims. I hereby authorize **XXX, LLC** and their representatives to furnish my insurance carrier any information I have provided on this form in order to obtain benefit and coverage information from my insurance carrier.

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| --- | --- |
| Patient/Guardian signature | Date |