

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 _____