Insurance Benefits Verification Form

This is the basic information you will need when you call your insurance company. If you have multiple children, please complete this form and verify benefits for each child. Some insurance companies have different rules depending upon the age of the child.

Child's Name:	DOB:
Insurance Company:	Insured ID #:
Group #:	Policy Holder's Name:
Policy Holder's DOB:	Effective Date:

Questions to Ask:

What is my deductible?	
Is Center for Speech, Language, and Learning Inc. an in-network provider?	**Yes** **No**
Are occupational therapy and speech therapy services covered under this plan?	**Yes** **No**
Are habilitative services covered for occupational therapy and speech therapy?	**Yes** **No**
Is there a limit to the number of visits per year?	**Yes** **No**
How many visits for each service?	
Do I have a co-payment or co-insurance that I'm responsible for?	**Yes** **No**
How much is the co-payment or co-insurance?	
What is required for medical necessity?	
Are there any exclusions or restrictions?	**Yes** **No**
What are they?	
Is prior authorization required for services?	**Yes** **No**
If prior authorization is required, where should that information be sent?	Fax number: Email:
Name of the representative you spoke with:	
Date of verification:	Call reference number: