INSURANCE VERIFICATION FORM

Please complete this form and email to ehoffart@greatleapsbc.com with a copy of the child's insurance card(s) – front and back.

CHILD'S INFORMATION

Last Name: _____ First Name: _____ DOB: _____

Gender: _____ Home Address: _____ City: _____

State: _____ Zip: _____ Diagnosis: _____ Date of Diagnosis: _____

CAREGIVER INFORMATION

Last Name: _____ First Name: _____

Home Address: _____ City: _____ State: _____

Zip: _____ Phone #: _____ Email: _____

Relationship to Child: _____

ADDITIONAL CAREGIVER

Last Name: _____ First Name: _____

Home Address: _____ City: _____ State: _____

Zip: _____ Phone #: _____ Email: _____

Relationship to Child: _____

PRIMARY INSURANCE

Insurance Provider: _____

Insurance Phone #: _____

Policy #: _____

Group #: _____

Subscribers Name: _____

Subscribers DOB: _____

Relationship to Child: _____

Employer: _____

SECONDARY INSURANCE

Insurance Provider: _____

Insurance Phone #: _____

Policy #: _____

Group #: _____

Subscribers Name: _____

Subscribers DOB: _____

Relationship to Child: _____

Employer: _____

I authorize the release of insurance and benefits information to Great Leaps Behavior Center I understand that a quote of benefits and/or authorization does not guarantee payment from my insurance company. Payment of benefits is subject to all terms, conditions, limitations, and exclusions of the member's contract at time of service. I understand that I am responsible for alerting my ABA provider of any changes in my insurance and/or payment status for services.

Caregiver Signature: _____ Date: _____