Verification of Benefits

_____

Tax ID: _____
NPI no._____
_____
_____

Appt Date: _____ Request date:_____

Patient Name: _____Birthdate_____

Patient Address _____

Patient tel number: _____ Primary Insurance _____

Primary Insurance company _____ ID# & Group No_____

Ins. Phone # for mental health: _____ Phone # other_____

Plan effective Date? _____ Plan type (PPO, POS, or HMO): _____

Does a 3rd party handle the mental health? _____ In or out-of-network _____

Benefits based on ____ Calendar year or Benefit year beginning _____

Deductibles: Individual $_____ (Amt Met?) _____ _____

Patient owes: Copayment: $_____ OR: % _____

Unlimited visits ?_____ or max limit of _____# visits per year _____

Referral needed for the 1st visit? _____
Pre-auth required? _____ If yes, obtain auth. Auth #_____
visits authorized: _____ (CPT code(s)) _____
Beginning date: _____ ending date: _____

Phone # to obtain reauthorization _____

Additional notes:

_____

_____

_____

_____

4. What is the claims mailing address for mental health claims?

_____

_____

_____

Call Reference: _____
Completed: _____