

Insurance Information:

Insurance Company \_\_\_\_\_ F/S # \_\_\_\_\_ /Payor ID# \_\_\_\_\_  
 Telephone # (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ FAX: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  
 Policy Holders Name \_\_\_\_\_ D.O.B: \_\_\_\_\_  Male  Female  
 Policy Holders Address \_\_\_\_\_ City \_\_\_\_\_ St. \_\_\_\_\_ Zip \_\_\_\_\_  
 Policy Holders ID# \_\_\_\_\_ Group # \_\_\_\_\_ SSN# \_\_\_\_\_  
 Policy Holders Employer (if covered through work) \_\_\_\_\_  
 Policy Holders relationship to Client \_\_\_\_\_

*Your insurance benefits are verified as a service to you and in no way should be taken as a guarantee your services will be paid for by your insurance company. We recommend you contact your insurance company as well, as you are ultimately responsible for charges.*

Is this an EAP? Yes No Is authorization needed? Yes No Authorization # \_\_\_\_\_ Employer: \_\_\_\_\_

**OFFICE USE ONLY BELOW**

**\*\*This is an estimate of benefits only, not a guarantee of payment.** Effective Date: \_\_\_\_\_

Policy Specifics:

	<u>In Network</u>	<u>Out of Network</u>
Payment per visit _____		
Mental health outpatient co-pay _____		
Visits per year _____		
Deductible _____ (\$Met)		
Benefit year period _____		
Maximum yearly benefit _____		
Maximum Lifetime benefit _____		
Referral needed? Yes No If yes, from whom? _____		

Precertification/Preauthorization required?  Yes  No

Out of Pocket Max: \_\_\_\_\_

If yes, please list/describe: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Benefit plan pays: 100% of first \$100.00 80% of next \$100.00 50% of the next : _____
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Limited Credentials Accepted? Yes No Any licensed professional

If yes, circle which credentials accepted: PhD LMLP LCP LMSW LSCSW LMFT LCMFT MD ARNP

Notes: \_\_\_\_\_  
 \_\_\_\_\_

Mail Mental Health Claims to: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Date this information obtained \_\_\_\_\_  
 Name of person talked with \_\_\_\_\_  
 Info. gathered by \_\_\_\_\_  
 \_\_\_\_\_

Reg. ID # \_\_\_\_\_ Client Name: \_\_\_\_\_