# INSURANCE VERIFICATION FORM

**APPOINTMENT DATE**: _____

**PSYCHOLOGIST**: _____

Patient Name: _____ DOB: _____

SSN:_____

Insurance Co.: _____ Phone #: _____

Policy Holder: _____

Employer/Insured: _____ ID #: _____

Group #: _____

Diagnosis/Reason for Visit:

_____

**BENEFITS: (Please call your insurance company to obtain the following information)**

What is my effective date? _____

What is my copayment amount? _____

Do I have a deductible? Yes No If yes, What is my deductible? _____
Has it been met this year? Yes No

What percentage of the charges does my plan pay? _____

Are the benefits different for a serious mental illness? Yes No If yes, what is the benefit?
_____

Is there a limit to the number of visits per year? Yes No If yes, what is the limit?_____

Is there a Pre-existing clause to my plan? Yes No

Is Pre-Authorization required? Yes No

Referral / Authorization #: _____ # Visits: _____ Effective dates:
_____

Spoke to: _____