Appointment Date: ______________________________

BENEFIT VERIFICATION & ELIGIBILITY

*** Please fill out the top of this form completely. VERIFICATION OF ELIGIBILITY & BENEFITS IS NOT A GUARANTEE OF REIMBURSEMENT**.

Therapist:	Credentials:	In Network	Out of Network
Billing Under:	Credentials:	New Patient	Transfer

Patient Name:		SS#:	
Patient DOB:	Male / Female	Contact Phone #:	
Street Address:		State:	Zip Code:

Insured Name:		SS#:	
Insured Street Address:		State:	Zip Code:
Insured DOB:	Employer:		
Insurance Carrier:		Insurance Telephone #:	
ID#:		Group #:	

OFFICE USE ONLY BELOW:

Current Plan Effective Date: ______________________	Visit Limit: ______________
Individual CPT Codes Covered: 90791, 90832, 90834, 90837	Family CPT Codes Covered: 90846, 90847

CPT	Deductible Amount	Co-Insurance Amount
90791	______________	______________
90832	______________	______________
90834	______________	______________
90837	______________	______________
90846	______________	______________
90847	______________	______________

	Individual	Family
Out of Pocket Max	$__________	$__________
Amount Met	$__________	$__________

Special Instructions / Exclusions:
Claims Mailing Address:
Electronic Payer ID #:

CoPay: $	Coinsurance:	Deductible – Individual: $ Met: $	Deductible – Family: $ Met: $
Authorization #:		Authorization Dates:	
Authorization Phone:		Authorization Fax:	
Verified By:		Date:	
Insurance Associate Name:		Reference #:	

Last Name	First	Middle		Date		Client #