INSURANCE VERIFICATION FORM

PRIMARY INSURANCE:

Client's relationship to the insured _____

Insured's name _____

Insured's address _____

Insured's Social Security # _____ Date of Birth:_____

Primary Insurance Company _____

Insurance address _____

Insurance Phone # _____

Insurance ID # _____ Group # _____

Deductible amount _____ Met? ( ) Yes ( ) No

Preauthorization required? ( ) No _____ If yes, through _____

Limits of mental health coverage _____

sessions/year _____ $ amount/year _____

SECONDARY INSURANCE

Client's relationship to the insured _____

Insured's name _____

Insured's address _____

Insured's Social Security # _____ Date of Birth:_____

Primary Insurance Company _____

Insurance address _____

Insurance Phone # _____

Insurance ID # _____ Group # _____

Deductible amount _____ Met? ( ) Yes ( ) No

Preauthorization required? ( ) No _____ If yes, through _____

Limits of mental health coverage _____

sessions/year _____ $ amount/year _____

Maggie Anderson LCSW has my permission to bill my insurance(s) (HMO, PPO, BAP). I authorize her to release any information necessary to process my claim. I further authorize my insurance benefits to be paid directly to Maggie Anderson LCSW.

→ _____ _____

SIGNATURE **DATE**