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Insurance Benefits Verification Form

Client's name:_____ Client's date of birth: _____

Client's Social Security: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone #: _____

Name of Insurance Company:_____

Phone # of Insurance Company: _____

Client's ID/SS #: _____

Policy #: _____ Group #: _____ Renewal date: _____

Name(s) of representative(s) spoken with: _____

1. Does my coverage include outpatient mental health benefits? [ ] Yes [ ] No
   (Individual Therapy CPT Codes: 90834 & 90837)

2. Does my coverage cover family/couples therapy? [ ] Yes [ ] No
   (CPT codes: 90846 & 90847)

3. Does my coverage include out-of-network providers? [ ] Yes [ ] No

4. Is there an out-of-network deductible? [ ] Yes [ ] No

   If yes: Out-of-network Deductible: $_____

   How much of the deductible has been met? $_____

5. After the deductible has been met, how much of the therapy session is covered by insurance?
   _____

6. How many sessions are allotted per year? _____

7. Is preauthorization or a referral needed? _____

   If yes, what is the process of acquiring preauthorization? _____

   _____

8. What information is required when filing a claim? _____