INITIAL CONTACT/INSURANCE VERIFICATION FORM

Appointment Date:_____ Provider:_____

Today's Date:_____ Received By:_____

Patient Information

Patient's Name:_____ DOB:_____

Parent/Guardian's Name:_____ SS #:_____

Address:_____

Phone: ( )_____ CP#: ( )_____

Type of Service Requested (circle all that apply): INDIVIDUAL FAMILY MARITAL GROUPS

Primary Insurance Information

Effective Date:_____

Insurance Co.:_____ ID#:_____

Ins. Phone:_____ Plan:_____ Group:_____

Subscriber Name:_____ Relationship to Subscriber: Self Spouse Child Other

Subscriber SS#:_____ DOB:_____ Employer:_____

Claims Address:_____

In Network: YES NO Calendar Year / Benefit Year:_____ Out-of-Pocket: $_____ Met: $_____

Deductible: $_____ Ded Met? YES NO Met: $_____

Copay/Co-ins:_____ Coverage:_____% Visits/Year:_____ Used:_____

Exclusion to Benefits: "V" Codes

Insurance Representative:_____ Verified By:_____ Today's Date:_____

Referral Required? YES NO from:_____ **Pre-Authorization Required? YES NO**

Managed Care Co.:_____ Phone:_____

Auth #:_____ Dates:_____to_____

Notes: Allowed Rate: 90791_____**/90837**_____**(Allowed rate will apply if goes to Deductible)**

Provider Collect from Patient Per Visit after Deductible:
Initial:$_____
Follow Up:$_____