Determination of Client Outpatient Mental Health Benefits

Insurance Verification / Form for Clients

***Please use this form and call your insurance company to verify your insurance benefits. Bring this form with you to your appointment.**

Client Name: ____**DOB**: _________________
Therapist's Name: Mary Ann Griffith, Haven Counseling

Insurance Information (Please circle): Primary Secondary Tertiary

Insurance Company: ____
Subscriber/Policy Holder's Name: ___________________________ DOB: ___________________
Subscriber/Policy Holder's Employer: ____
Subscriber/Policy Holder's SS#:____

ID# on card: ____
Group#:________________________________ Benefits Phone: _________________________
Authorization Phone: __________________________________

Other Information: ____

Name of Insurance Contact/Representative:___________________________________

Date: ______________ Effective Date: ______________ HMO PPO POS Out of Network benefits? Y N

Deductible: ______ Benefit year: ___________________ Deductible Met? _________________

Individual Deductible remaining: $_________________ **Family Deductible remaining**: $_____________

Co-Pay: _______________**Co-Ins**: ______________________

Other: ___________________________ Authorization required? Y N
____

**Are there any excluded mental health benefits? (ie: Family sessions?)
____

**Any excluded diagnoses? (ie: ADHD)
____

**Is Authorization required for Psychological Testing:
____

AUTHORIZATION

Address for Claims: ____

____

What sessions are included on the Authorization? (Please circle all that apply): 90801 90806 90847 90837 90834