660 Linton Blvd, Delray Beach, FL 33444
Appointments: 561-272-8880 | Counselingservicesassoc@gmail.com

INSURANCE VERIFICATION FORM

Today's Date ________________

Patient's Name: ___________________________________

DOB ______________

ID# _____________________________ Group # ________________________

Insurance Company ____

Insurance Phone (   ) ___________________ Effective Date _____________

Is this an in-network claim? _______________

Do you have Out-of-Network benefits? ________________

Do you have a deductible?________________________

What is the **deductible amount**? _________________________

Has the **deductible been met**?   YES   NO

Do you have a **Co-pay** $__________ or **Co-Insurance** ______%

Is there a **maximum number of visits** allowed?   YES   NO

If so, how many? _______

Are there any limitations, restrictions or pre-existing conditions we should know about?
____

____