INTEGRATED MENTAL HEALTH ASSOCIATES

Insurance Verification Form and Patient Information

Asterisk (*) means required

Patient/Subscriber Information

*Patient Name: _____ Date of Birth: _____

*Home Address: _____

City State Zip

*Subscriber Name (if different from patient name): _____

*Relationship to Patient: _____ Subscriber's Date of Birth (if different): _____

Benefit Verification

*Insurance Company Name: _____

*Insurance I.D. Number (include letters): _____

*Insurance Phone # Called: _____

Spoke with: _____

Effective Date of Coverage: _____ Deductible: _____

Deductible Amount Met: _____ Copay: _____ Visit Maximum: _____

*Authorization Required: Y N *If YES, Authorization Number: _____

*Start and End Dates of Authorization: _____

*Specific Codes Authorized: _____

Mail Claims to:

_____

_____

_____

_____

IMPORTANT – PLEASE READ:

*Items that have an asterisk next to them indicate required fields that must be completed prior to the first appointment. Some insurance companies require that Authorization is obtained no later than the day of the first appointment. If you are unable to call for authorization before your session, we will need to do so while we meet - this can take 15-30 minutes away from you being able to address the reasons you've come. Thank you for your understanding.