

PATIENT INSURANCE VERIFICATION OF BENEFITS FORM
(Please Complete in Full)

Patient Name _____ DOB ____/____/_____

Patient Address _____ Soc. Sec.# _____

Patient Phone # _____

Policyholder Name _____ Policyholder DOB ____/____/_____
Policyholder Soc.Sec.# _____ Employer _____
Insurance Co. _____ Mental Health Phone # _____
Policy ID# _____ Group ID# _____ Eff. Date _____

***** PLEASE call your insurance company at least two days prior to your appointment to obtain proper authorization for this visit. A call is required as your mental health benefits may differ from your medical benefits. If you do not obtain the following requested information you will be responsible for the full appointment fee. (This page NOT required for MEDICARE patients) *****

Ask your representative the following questions:

Mental Health Claims Address:

Do I have outpatient mental health benefits? Yes or No
Is Dr. Sandra Diehl in network? Yes or No
Do I have out of network benefits? Yes or No
Copay Amount \$ _____
Deductible Amount \$ _____
Has it been met? Yes or No
Coinsurance Percentage ____/____
Does my Deductible apply towards office visits? Yes or No
Are authorizations required for a:
(New Patient) Yes or No
(Medication Management/Therapy) Yes or No
(Medication Management) Yes or No
Authorization # _____
How many visits are approved # _____
Auth. Start Date: _____
Auth. End Date: _____
How many visits per year am I allowed? # _____
Plan's lifetime maximum benefit? _____

Patient
Signature: _____ **Rep.** _____ **Date:** _____

We hope that this information will help you understand the mental health benefits of your insurance plan. Please arrive 30 minutes prior to your first appointment. Please understand that we do not accept financial responsibility for patients who see a provider who is not in network and/or benefits that are not covered under your insurance plan. Please note that missed appointments are not covered by your insurance plan.