INSURANCE VERIFICATION FORM

CLIENT INFORMATION (CHILD RECEIVING SERVICES)

LAST NAME: _____ FIRST NAME: _____ DOB: _____ GENDER: _____

HOME ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

DIAGNOSIS: _____ PRIMARY CARE PHYSICIAN: _____ PCP PHONE: _____

FINANCIALLY RESPOSIBLE PARTY

LAST NAME: _____ FIRST NAME: _____ EMAIL: _____

HOME ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

SPOUSE LAST NAME: _____ SPOUSE FIRST NAME: _____ EMAIL: _____

HOME PHONE NUMBER: _____ CELL NUMBER: _____ WORK NUMBER: _____

PRIMARY INSURANCE

INSURANCE CO: _____

SUBSCRIBERS NAME: _____

SUBSCRIBERS DOB: _____

EMPLOYER: _____

POLICY ID: _____

GROUP #: _____

INSURANCE PHONE #: _____

SECONDARY INSURANCE

INSURANCE CO: _____

SUBSCRIBERS NAME: _____

SUBSCRIBERS DOB: _____

EMPLOYER: _____

POLICY ID: _____

GROUP #: _____

INSURANCE PHONE #: _____