Provider Name: ___________________________ Phone:__________________________ Date:_______________

Behavioral Health Insurance Verification

Patient Name:	DOB:	Id#:	Group#:
Primary Policy Holder:	DOB:	Id#:	Group#:
Insurance company:			
Does Deductible Apply to Behavioral Health:	☐ Y ☐ N		
Co-pay:			
Visit Limit per year:			
Prior Authorization Required?	☐ Y ☐ N		
Out of network Benefits?	☐ Y ☐ N	Deductible:	Co-pay:

Once you have this information, please call your providers office and schedule your next appointment. If you aren't able to obtain this information, don't worry. Call your providers office or send me an email with your data completed in the form and we can assist. We are her to support you.