INSURANCE BENEFITS/ELIGIBILITY VERIFICATION FORM

Notification of Benefits to Provider: A quote of benefits and/or authorization does not guarantee payment. Payment of benefits is subject to all terms, conditions, limitations, and exclusions of the member's contract at time of service.

Benefits Verification							
Patient Name:			DOB:		Member ID:		
Subscriber Name:			DOB:				
Dx Code				Dx Description:			
Provider				NPI:		Tax ID:	
Service Location Address:							
Insurance Co./Phone #							
Insurance Rep/ Call Ref #							
Policy Effective Date				Plan Period:			
Provider in Network?				Self or Fully Funded?		State for Fully:	
Benefit Max (session, $, age cap, etc.)							
Benefits/Eligibility for:	ABA	SLP	OT		ABA	SLP	OT
	IN-Network				**OUT-of-Network**		
Co-pay $							
Individual Deductible $							
Ind Deductible Met to date							
Fam. Deductible							
Fa. Deductible Met to date							
Cost Share %							
Individual OOP Max							
Individual OOP Max Met							
Fam. OOP Max							
Fam. OOP Max Met							
Company Paying Claims							
Electronic Payer ID							
Claims Sent to							
Authorization Info:	Required?		Auth Phone #		Company for Auth		
Codes Valid for ABA:							
Notes:							

Employee Completing Call ______________________ Date of Call: __________ Time of Call: __________