INSURANCE VERIFICATION - Lynda Green-Alter, MFT

Patient Name: ____ Date of first contact: ____________

Phone #s: work # (_____) _________________ home # (_____) _________________

Email Address: ___________________________________ Cell # (_____) _________________

Pt's STREET Address: ___________________________________ City: ____________ Zip: ________

Referred by (who gave you Lynda Green-Alter's name / phone #?): ___________________________

Policyholder's Name: __________________________________ relationship to patient: __________

Primary insurance company: ____

Policy / ID #: _______________________ SS # ____________________ Group #: _____________

Insured's date of birth: __________________ Patient's date of birth: ___________________

Insurance Phone # (____) ________________ (usually on back of card as "customer svc" or "provider's call")

Ask patient if there is a separate number listed on back of card for "mental health"? (____) _____________

APPOINTMENT: Date: ___________________ Time: ______________

Date contacted insurance: ____________ Name of person spoken to: _______________ Ext #:____

Plan Effective Date? _________ Plan Type (PPO, POS or HMO): _______ Termination Date? _______

If effective less than 1 year ago – is pre-existing applicable? Y N For how long?: ______________

Mail Claims to: ____

Patient's owes: Co-Payment: $_______ OR : _____________________________________

Insurance pays: ____

Deductible: Indiv. $____ (Amt Met? $____) Family $____ (Amt Met? $____) Carry-over? Y N

Out of Pocket Max Per Year: Indiv. $______ (Met? $_____) Family: $______ (Met? $_______)

Is Lynda Green-Alter a participating provider ("in network")? Y N (see contract rates below)

If "non-par", do LGA's cash rates fall within U&C? 90791: _____ 90832: _____ 90834: _____ **90837**: _____ 90847: _____

Maximum covered: __________ # visits per year EAP visits: _____________________

Any different coverage under **Parity Act** (AB-88)? Y N ________________________________

Pre-Auth Required? Y N If yes, **ask for auth!** Auth # ________________________

authorized: _________ (CPT code(s) _______________) Auth start date: ______ end date: _______

NOTES: ____