INSURANCE VERIFICATION - Lynda Green-Alter, MFT

Patient Name: _____ Date of first contact: _____

Phone #s: work # (___) _____ home # (___) _____ cell # (___) _____

Pt's STREET Address: _____ City: _____ Zip: _____

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

Policyholder's Name: _____ relationship to patient: _____

(ask patient to get out their insurance card) If TWO insurance policies, fill out another form too!

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

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

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

Maximum covered: _____ # visits per year $ _____ per year / lifetime

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

authorized: _____ (CPT code(s) _____) Auth start date: _____ end date: _____

Does policy fall under **Parity Act** (AB-88) coverage? Y N NOTE: "self-funded plans" are excluded!

Patient pays if Parity diagnosis: _____

Insurance pays if Parity diagnosis: _____

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

Maximum covered: unlimited # of visits per year Maximum out-of-pocket? $_____ per year

NOTES: _____