INSURANCE AUTHORIZATION OF BENEFITS

Date: ________________ Therapist: ____

Name of Client: First: _____________________ Middle _____ Last _______________________

Phone number: _________________________ Date of Birth: __________________

Insurance Company for Mental Health Benefits: *(very important-often a different company)*

Name of Insurance Company: ____

Address of Insurance Company: ____

Phone Number of Insurance Company: _______________________________

Primary __________ Secondary ___________

Subscriber Name: ____

SSN: _________________________________ Date of Birth: _____________

Relationship of Subscriber to Client: Self Spouse Parent Guardian Other_________________

Subscriber ID #: ________________________ Group ID #: ____________________________

Effective Date: _________________________ Employer: ____________________________

Another Health Plan? Yes ______ No ______ Address: _____________________________

(For insurance purposes only)

Please attach copy of insurance card (front & back)

I authorize payment of medical benefits to Stacey S. Ward, LCSW, PLLC. Mrs. Ward will file my claim for me, and refile if necessary, but will not assume responsibility for collecting on my insurance claim or negotiating settlement on a disputed claim. **If my insurance does not pay my claim, I understand that it will be my responsibility to pay.**

Signed ____ Date ___________________

For Office Use Only

DSM IV number: __________________________

Contact name: __________________________________ Date verified: ______________

Claims Mailing Address:____

Deductible: _____________ Deductible met? Yes ____ No ____

Co-Pay: ________________ In network? Yes ____ No ____

Authorization needed? Yes ____ No ____ Authorization number: _______________________

Number of sessions authorized: _____________

Allowed CPT Codes:____