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 Lepa Modie LCSW, PLLC. Lepa Modie LCSW will file my claim for me, and re-file 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:____