Donna Henn MS, LPC

INSURANCE VERIFICATION

Complete & Fax to: billing office at (713) 472-0771

Patient Name: _____ DOB: _____ SS# _____ Parent: _____

Address: _____ City, State, Zip: _____

Home Phone: _____ Ok to call? ____ Alt./Cell Phone: _____ Ok to call? ____

Email Address: _____ Other Ph: _____

Referred By: _____ Misc:: _____

Primary

Insurance Co: _____ Phone: _____ Psych Carrier: _____ Phone: _____

Claims Address: _____

ID # / Claim # _____ Group # _____ Payor ID _____

Name of Insured: _____ Insured DOB: _____ Insured SS# _____

Secondary (If applicable)

Insurance Co: _____ Phone: _____ Psych Carrier: _____ Phone: _____

Claims Address: _____

ID # / Claim # _____ Group # _____ Payor ID _____

Name of Insured: _____ Insured DOB: _____ Insured SS# _____

IN NETWORK (completed by office)

Effective Date: _____

Deductible: _____ Met: _____

Co-Insur: _____ Co-Pay: _____

Limitations: _____ Plan Yr: _____

OOP: _____ Pre-Cert Required: YES / NO

Auth # _____ Dates: _____

90801 - _____
90806 - _____
90847 - _____
90857 - _____
96101 - _____

Other: _____

Representative: _____

_____

EAP

Carrier: _____ Ph: _____

Address: _____

_____

Limitations: _____ Dates: _____

Auth # _____

Additional Info / Instructions:

Verified By: _____ Date: _____

NOTES: