Insurance Verification Form

First Name: _____ **Last Name:** _____ **Middle Initial:** _____

Address: _____ **City:** _____ **St:** _____ **Zip:** _____

Home Telephone #: _____ **Alternate Telephone #:** _____

Date of Birth: _____/_____/_____ **Social Security No.:** _____-_____-_____ **Sex:** _____

Marital Status: ( ) Single ( ) Married ( ) Divorced ( ) Separated ( ) Other: _____ **Age:** _____

Responsible Party: _____ **Email address:** _____

Relationship to patient: _____ **Occupation:** _____ **Work Telephone:** _____

Employer: _____**Email:** _____

Patients Spouse or Parent (If Minor): _____ **Telephone #:** _____

Emergency Contact: _____ **Telephone #:** _____

You may be contacted by Transformation Behavioral Health, LLC billing agency, Clear-Solutions, LLC if additional information is needed or for any questions the agency may have to verify your insurance benefits to determine amount of copay, coinsurance or out-of-pocket payment is required prior to your scheduled appointment. Thanks

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Insurance Information

Company Name: _____ **Telephone #:** _____**Policy No.:** _____

Group No.: _____ **Policy Holder's Social Security No. (if different from Patient):** _____-_____-_____

Policy Holder (if different from Patient): _____ **Relationship:** _____

DO NOT Write below this line:

TO BE COMPLETED BY BILLING OFFICE

Date: _____ **Spoke with:** _____ **Circle one: In Network Out of Network**

Policy Effective: _____ **Co pay Per Visit: $**_____ **Coinsurance Per Visit:** _____

Deductible Amount: $_____ **Deductible Met: $**_____ **Max Visits/Max Payable Per Year:** _____

Out of Pocket Max Per Year: _____ **Exclusions to policy:** _____

Claims Address: _____ **City:** _____ **St:** _____ **Zip:** _____

Authorization #: _____ **Sessions Approved:** ____ **Authorization Date:** _____ **thru** _____

Notes: _____

**PLEASE FAX OR EMAIL FORM TO:
Fax#: 866-750-0025 or Email:
info@transformation3cs.com