

**DARSHANA-LMFT
CLIENT INSURANCE VERIFICATION FORM**

Today's Date: _____ 1st Scheduled Appt. _____ Verified by: _____

Client Name _____ DOB _____ SSN _____

Address _____

Home Phone: _____ Work Phone _____ Cell Phone _____

Insured Name _____ Insured's Employer _____

Insured's Address (if different) _____ Insured's SSN _____

Insurance Company _____ Mental Health Insurance _____

Client Insurance ID# _____ Insurance Phone _____

Insurance Contact Name _____ Ref. # _____

Requested Therapist _____ In Network/Out of Network (circle one)
(If out of network, see below)

Therapist Payer ID # (for electronic billing) _____

Therapist NPI (National Provider Identification) Number: _____

Effective date of policy _____ Annual deductible _____ Deductible met? \$ _____

Annual max sessions _____ Lifetime max sessions _____

Copay \$ _____ Does copay change after 1st visit? _____ Percent Reimbursement _____

Authorization Required? YES NO Authorization No. _____

No. of Sessions Authorized _____ Date Range _____

Claims Address: _____

REMARKS _____

IF OUT OF NETWORK:

Deductible _____ Annual max sessions _____ Copay \$ _____ % Reimburse _____