SURPRISE BEHAVIORAL HEALTH
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 _____Insured's DOB _____

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: _____

_____

_____

IF OUT OF NETWORK:

Deductible_____ Annual max sessions_____ Copay $_____ % Reimburse _____