Insurance Verification and Billing Authorization Form

Date:_______________ Taken By:____________________________

Referal Source Information

Referal Source: _________________________Case Manager's / Contact Name: _______________________________

Contacts Phone #: __________________________ Contact Email: ____

Client Information

Clients Name:_________________________________ DOB:________________ Male ______ Female ______

Social Security #:_________________________________ Phone #:__________________________

Address:__________________________________ City:_____________________________ ZIP:___________

Insurance ID#________________________ Group:_______________

Insurance Company:___________________________ Phone#_____________________________

Effective Date_________________ Plan Type:_________________ BP In-Network Y N

Admissions

Pre-Cert Authorization #_______________________ Start Date______________ # of Units______________

Insurance Rep Name:___________________________________ Date_______________________

Pre-Cert Autorization Required YES NO Pre-Cert Authorization Phone#____________________

Primary Diagnosis: _____________________________ Secondary Diagnosis: ______________________

Comments

Notes:____

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