

Harmony Heals, Inc



INSURANCE VERIFICATION

Client Name: _____ Date of Birth: _____

Name of Insured: _____ Relationship to Insured: _____

Primary Insurance: _____ Secondary: _____

Insurance Company Address: _____

Insured Social Security Number: _____

Policy Number: _____ Group Number: _____

Employer: _____ Phone: _____ Effective Date: _____

IN-PATIENT PSYCHIATRIC

Hospital Benefits: _____ Stop/Loss: _____ Misc: _____ Deductible: _____

Professional Benefits: _____ Deductible: _____ Met: _____ MD/PHD Same Day

Different Diagnosis Required: _____ Psych. Testing: _____

Paid As a Visit: _____ Maximum Benefit Testing: _____ Group: _____

Family: _____ Biofeedback: _____ Therapeutic Passes: Day: _____ Night: _____

PhD: _____ MFT: _____ LCSW: _____ Maximum Lifetime: _____

Yearly Maximum: _____ Number of Days: _____ Maximum Lifetime Used: _____

Yearly Maximum Used: _____ Electric Convulsive Therapy: _____

Partial Hospitalization: _____ RTC: _____ Polysomnography: _____

DRUG AND ALCOHOL

Drug Related: _____ Maximum: _____ Paid Exactly as Above: _____

Alcohol Related: _____ Limitations: _____ Maximum: _____

OUT-PATIENT PSYCHIATRIC

Deductible: _____ Paid At: _____ Yearly Max: _____

Psych. Testing: _____ Group: _____ Lifetime: _____

Family: _____ Biofeedback- (Psych. Or Medical): _____

Pre-Authorized: _____ Phone Number: _____

Pre-Authorization required for In-Patient: Yes _____ No _____ Phone: _____

Pre-Existing Clause: _____ Primary Physician: _____ Primary Therapist: _____

Contact @ Ins. Co. _____ Verified By: _____ Date: _____

I hereby declare the above information is true and accurate and that I am legally responsible for all charges incurred. I also understand that a 24-hour notice of cancellation is required to avoid a charge.

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