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: _________________
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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: ______________________
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DRUG AND ALCOHOL

Drug Related: _______________________ Maximum: _____________ Paid Exactly as Above: ___________

Alcohol Related: _____________________ Limitations: ____________ Maximum: ______________________

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OUT-PATIENT PSYCHIATRIC

Deductible: ___________________ Paid At: __________________ Yearly Max: _________________________

Psych. Testing: ________________ Group: ___________________ Lifetime: ____________________________

Family: _____________ Biofeedback- (Psych. Or Medical):____

Pre-Authorized: _________________ Phone Number: ____

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

Pre-Existing Clause: _____________Primary Physician: _________________Primary Therapist: _____________

Contact @ Ins. Co._____________________ Verified By: ________________ Date: ______________________

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