

___EAP ___Counseling Services ___Testing ___Other

GENERAL INSURANCE: _____ PHONE# _____

SPECIALITY PROGRAM: _____ (upper right hand side of card)

MENTAL HEALTH PROGRAM: _____ PHONE# _____

(If different from general insurance; this information is usually on the back of the client's ins. card)

CARD HOLDER'S EMPLOYER _____

CARD HOLDER'S NAME: _____ /Birthdate: _____

ID# FROM CARD: _____ /SS# _____ Relationship to client _____

GROUP NUMBER (if any) _____

EAP PROGRAM: _____ PHONE# _____

INSURANCE VERIFICATION

Information from: _____

Contracted Invoice Rates: 90801 _____ 90806 _____ 90847 _____
PSY _____

SW / LPC _____

Copay: _____ Insurance effective date: _____

Deductible: _____

#Sessions avail: _____

Mailing Address for Claims: (payor) _____

Attn: _____

Precert/Authorization: _____

TELEPHONE CALL LOG
(Tracking of calls made to client to schedule)

DATE OF CALL: TIME OF CALL: DISPOSITION OF CALL:

1.

2.

3.