Anan & Associates

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Mental Health Insurance Verification and Eligibility Form*

Please provide the following information in boxes below:

Intake appointment date: _____

Patient's Name: _____ Therapist Name: _____

Patient's DOB: _____ ☐ Male ☐ Female

Street Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell phone: _____

Insured's Name: _____ SS# of Insured: _____

Insured's DOB: _____ Employer: _____

Insurance Name: _____ Insurance Phone #: _____

ID/Claim #: _____ Group #: _____

PLEASE LEAVE THE REST OF THIS FORM BLANK. This section will be completed by therapist & billing company:

Dx Code: _____ Eff Date: _____ In Network / Out of Network

CPT Codes: 90791 / 90832 / 90834 / 90837 Family Therapy covered: **Y / N** 90846 / 90847

Testing covered: **Y / N** 96130 / 96131 / 96132 / 96133 / 96136 / 96137 / 96138 / 96139

EXCLUSIONS ON THE POLICY:

Mail Claims To: _____ # of visits per cal yr: _____

_____ Copay / Coins: _____ Deductible: _____

_____ Ded Met: _____

Authorization #: _____ Dates: _____

Authorization ph #: _____ # of visits that auth covers: _____

Separate auth required for testing: **Y / N** Does a form need to be submitted: **Y / N**

Testing auth ph #: _____ Fax #: _____

Verified By: _____ Sharlabo Mental Health Billing Associate Date: _____

Insurance Associate Name: _____ Call ref Number: _____

**This verification of eligibility and benefits is not a guarantee of reimbursement*