Olive Branch Counseling and Training

Insurance Verification Form

Date: _____ Existing Patient / New Patient

Patient's Name: _____ Phone: _____

Patient's SSN: _____ DOB: _____

Address: _____

City: _____ State: TX Zip: _____

Patient e-mail address: _____

Insured's Name: _____ DOB: _____

Insured's SSN: _____

Insurance Company: _____ Ins Phone: On File

Initial Appt Date: _____ Dx: _____

ID #: _____ **Group #:** _____

(Complete to this line)

Effective date of policy: _____ Calendar / Fiscal

Network Status: **IN OUT** Covered Services: **SMI Family 30min 45min 60min**

Deductible: _____ Deductible Met: _____ Co- Insurance: _____

Co-pay: _____ Yearly Visit Limitations: _____

Pre-Authorization Required: **No Yes** Auth # _____

Auth # Effective Dates _____ thru _____ # of Visits: _____

Referral from PCP Required: **Yes No**

Contracted Rates

Initial Session: _____ Follow up sessions: _____

Mail Claims to: _____

Payor ID: On File Spoke with: _____

Fax info to TDI Services: Date: _____

E-mail info to provider: Date: _____

*This is only an estimation of benefits and all payments are subject to policy guidelines, medical necessity and member eligibility at the time services are performed.

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