Insurance Verification Form

Name ________________________________

DOB ______________

Subscriber's Name _____________________________

Subscriber's DOB _______________

Insurance Company ________________________________

Member ID __________________________________

Group # _____________________

Employer____

Provider Phone # ____________________________

Deductible ____________ How much met? __________

How much remaining? ____________

Co-Pay ______ Pre-auth required? ________

# of sessions authorized _________

Limitations ____

Office Ally name ____________________