**Impact Health LLC**
**CLIENT INSURANCE VERIFICATION FORM**

Today's Date:_________ 1st Scheduled Appt._________ Verified by:_______________________

**Client Name**________________________________________ DOB _______________ SSN_____________________

Address ______________________________________________________________________________________________

Home Phone:______________________ Work Phone ____________________ Cell Phone ____________________

**Insured Name**____________________________ Insured's Employer___________________________________

Insured's Address (if different)__________________________________________Insured's SSN ________________

Insurance Company______________________________ Mental Health Insurance_________________________

Client Insurance ID#___________________________ Insurance Phone ___________________________________

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Insurance Contact Name______________________________ Ref. #_________________________________________

Requested Therapist_____________________________________ In Network/Out of Network (circle one)
*(If out of network, see below)*

Therapist Payer ID # (for electronic billing)______________________________________________________________

Therapist NPI (National Provider Identification) Number: ________________________________________________

Effective date of policy_______________ Annual deductible_________________ Deductible met? $__________

Annual max sessions_______ Lifetime max sessions ________

Copay $__________ Does copay change after 1st visit? ________ Percent Reimbursement ______________

Authorization Required? YES NO Authorization No.____________________________________________

No. of Sessions Authorized_________ Date Range__________________________________________________

Claims Address: _________________________________________________________

_________________________________________________________

_________________________________________________________

**REMARKS**___________________________________________________________________________________________

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**IF OUT OF NETWORK:**

Deductible__________ Annual max sessions___________ Copay $____________ % Reimburse ___________