SPEECH THERAPY ASSOCIATES LLC

Health Insurance Verification Form

Patient Name:	**Date of Birth:**

Primary Insurance:		
_____ In Network	_____ Out of Network	Insurance phone #:
Member Name:		Employer:
Member ID #:		Group #:
Effective Date:		Co-Pay Amount: $ _____
Deductible: Individual: $ _____	Family: $ _____	Out-of-pocket max: $ _____
Progress towards deductible to date:		
Coverage for therapy services:		Pre-authorization required? ____ Yes ____ No
Referral required? ____ Yes ____ No		Number of visits allowed:
Additional details / documents needed:		

Secondary Insurance:		
_____ In Network	_____ Out of Network	Insurance phone #:
Member Name:		Employer:
Member ID #:		Group #:
Effective Date:		Co-Pay Amount: $ _____
Deductible: Individual: $ _____	Family: $ _____	Out-of-pocket max: $ _____
Progress towards deductible to date:		
Coverage for therapy services:		Pre-authorization required? ____ Yes ____ No
Referral required? ____ Yes ____ No		Number of visits allowed:
Additional details / documents needed:		

Insurance company spoken with: _____ Primary Insurance _____ Secondary Insurance	
Authorization Number:	Call Reference Number:
Date and Time of Call:	Person Spoken With:
Notes:	