

# Insurance Verification Form

Please complete the top part of this form and email it to [brittany@planocounseling.org](mailto:brittany@planocounseling.org) or fax it to CCA at 972-422-2711 Attn: Brittany with a copy of the front and back of your insurance card if possible – otherwise just bring your card with you to your first appointment.

Counselor: Brittany Crim, M.A., LPC

Client Name: \_\_\_\_\_

Insurance Carrier: \_\_\_\_\_  
(If your carrier is BCBS, please include which state handles your benefits; i.e, BCBS-TX)

Insured Name: \_\_\_\_\_ (Rel to Client: \_\_\_\_\_)

DOB of Insured: \_\_\_\_\_ DOB of Client: \_\_\_\_\_

Home Address: \_\_\_\_\_ City: \_\_\_\_\_ Zipcode: \_\_\_\_\_

ID #: \_\_\_\_\_ Group #: \_\_\_\_\_

Phone # for Benefits: \_\_\_\_\_

Date: \_\_\_\_\_ Spoke to: \_\_\_\_\_

Policy Effective Date: \_\_\_\_\_

Pre-existing Condition? None \_\_\_\_\_

Copay Amount: \$ \_\_\_\_\_ Co-Insurance Amt: \_\_\_\_\_% Session Fees: \$ \_\_\_\_\_

Individual Deductible: \$ \_\_\_\_\_ Amount Met: \$ \_\_\_\_\_

Family Deductible: \$ \_\_\_\_\_ Amount Met: \$ \_\_\_\_\_

Out of Pocket: \$ \_\_\_\_\_

Max Visits: \_\_\_\_\_

Therapies Covered:      Individual      Marital      Family      Group

Precertification Required?    Y    N

Precertification. Phone #: \_\_\_\_\_

Rep: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_

Authorization #: \_\_\_\_\_

\_\_\_\_\_ Visits Authorized from \_\_\_\_\_ to \_\_\_\_\_