JETTMORGAN
TREATMENT SERVICES, LLC
Neuroscience of Change

INSURANCE VERIFICATION FORM

*Please Note: This information below is requested when a claim is submitted. Fill completely.

Date: _____ Client Name: _____DOB:_____

Address: _____ Phone_____ SSN:_____

If you have insurance, would you like us to bill them? **(Initial one)** _____ Yes _____ Decline

If declined, you are not eligible for the sliding fee scale and you will need to pay in full for all services rendered. I acknowledge my understanding **(Initial)** _____

If you would like for us to bill your insurance company, provide a copy of your insurance card.

Insurance Co. Name: _____

Insurance Phone: _____ Insurance Fax: _____

Member ID:_____ Group: _____ Employer: _____

Policy Holder Name: _____ Policy Holder DOB: _____

Address: _____ Phone: _____

(if different then your information)

Policy Holder DOB: _____ Relation to Client: Self Spouse Child Other

*** Staff Use Only ***

Verification Completed By:_____ Date: _____

Effective Date of Policy: _____ Pre-certification Required: Yes No

Individual Deductible: $_____ YTD Met: $_____ Assess. Payable: _____

Max. Out of Pocket: $_____ YTD Met: $_____ Diagnosis: _____ _____ _____

Co-Pay: $_____ Insurance/Client Payment Ratio:_____%/_____%

Max. Sessions Allowed: Per Year_____ Hourly Cap: _____Contact Name: _____

Reference # _____Notes: _____

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