INSURANCE AUTHORIZATION OF BENEFITS

Name of Client: First: ______________________ Middle: _____ Last: _________________________

Address:____ City:_______________ State:________ Zip:_________

Phone number: ___________________________ Date of Birth: ____________________

Insurance Company for Mental Health Benefits: *(very important-often a different company)*

Name of Insurance Company: ____

Address of Insurance Company: ____

Phone Number of Insurance Company: _________________________________

Primary __________ Secondary ___________

Subscriber Name: ____

SSN: ____________________________________ Date of Birth: ______________

Relationship of Subscriber to Client: Self Spouse Parent Guardian Other__________________

Subscriber ID #: __________________________ Group ID #: ______________________________

Effective Date: ___________________________ Employer: ______________________________

Another Health Plan? Yes ______ No ______ Address: _______________________________

(For insurance purposes only)

Please attach copy of insurance card (front & back)

I authorize payment of medical benefits to Balanced Choices, PLLC. Balanced Choices will file my claim for me, and refile if necessary, but will not assume responsibility for collecting on my insurance claim or negotiating settlement on a disputed claim. **If my insurance does not pay my claim, I understand that it will be my responsibility to pay.**

Signed ____ Date _____________________

For Office Use Only

DSM IV number: ____________________________

Contact name: _____________________________________ Date verified: ________________

Claims Mailing Address:____

Deductible: ______________ Deductible met? Yes ____ No ____

Co-Pay: _________________ In network? Yes ____ No ____

Authorization needed? Yes ____ No ____ Authorization number: _________________________

Number of sessions authorized: ______________

Allowed CPT Codes:____