Eberhart Counseling, LLC
Ellen Eberhart, LCMHC, MLADC

INSURANCE VERIFICATION/AUTHORIZATION

Please speak to a representative from you insurance company while filling out this form. Please make your best attempt to fill out form in full. *If you are unable to fill out a portion of this form please contact me prior to our first appointment.*

CLIENT NAME _____ DOB _____

Primary Insurance Company _____ID #_____

Telephone (Mental Health) # _____ Group #_____

Address _____Payor ID # _____

BENEFITS: (Outpatient Mental Health)

Copay _____Deductible_____ Calendar Year _____to _____

Parity Clause Yes / No Other Coverage Info _____

AUTHORIZATION:

*Is Authorization Required? ___Yes ___No

Initial Authorization # _____
Date Range _____to _____

*****PLEASE ASK*****: After how many visits does the therapist need to submit more paperwork for further authorized sessions?_____

Date Authorization Obtained _____ Signed by _____

If there is more than one insurance company providing coverage, be sure to fill out the next sheet, if not please ignore.

SECONDARY INSURANCE VERIFICATION/AUTHORIZATION

Please verify which insurance is considered the primary insurance and fill out accordingly.

(Please complete for Additional Insurance Coverage)

SECONDARY Insurance Company _____ID _____

Telephone (Mental Health) # _____Group #_____

Address _____Payor ID # _____

BENEFITS: (Outpatient Mental Health)

Copay _____Deductible_____ Calendar Year _____to _____

Parity Clause Yes / No Other Coverage Info _____

AUTHORIZATION:

*Is Authorization Required? ___Yes ___No

Initial Authorization # _____
Date Range _____to _____

After how many visits does the therapist need to submit more paperwork for further authorized sessions?_____

Date Authorization Obtained _____ Signed by _____