ABA THERAPY: Initial Insurance Verification

Complete Form and Return To: _____

******Must include Copy or Photo Front & Back of Insurance Card(s)**

Child's Name _____ Date of Birth: _____ Gender: _____

Does child have an Autism Spectrum Disorder Diagnosis? (Y/N) _____ (Please submit copy of diagnostic report)

Date of Diagnostic Evaluation: _____ Name of Doctor: _____

Any other Diagnoses? If so, please list: _____

PRIMARY INSURANCE

Name of Subscriber: _____ Is this a Medicaid policy? (Y/N) _____

Insurance Company: _____ Policy/Member ID: _____

Relation to Child: _____ Subscriber Date of Birth: _____

Address: _____

SECONDARY INSURANCE

Name of Subscriber: _____ Is this a Medicaid Policy? (Y?N): _____

Insurance Company: _____ Policy/Member ID: _____

Relation to Child: _____ Subscriber Date of Birth: _____

Address (If different from above): _____

Name of Primary Contact Parent/Gradian: _____

Home Phone: _____Cell Phone:_____

Email: _____

Preferred method of communication during business hours: _____

I authorize the release of insurance and benefits information to ___(*insert company name*)_____. I understand that a quote of benefits and/or authorization does not guarantee payment from my insurance company. Payment of benefits is subject to all terms, conditions, limitations, and exclusions of the member's contract at time of service. I understand that I am responsible for alerting my ABA provider of any changes in my insurance and/or payment status for services.

_____

Signature/Release Date