VERIFICATION OF BENEFITS FORM

Appointment date/Time: ____________

Information from Client:

Minor ☐

Name: ______________________

Address: ______________________

____

____

DOB: ______________________

Soc. Sec.#: ______________________

Home Phone: ______________________

Cell Phone: ______________________

Emergency Contact# ______________________

Name: ______________________

Insurance/EAP Co: ______________________

Policyholder name: ______________________

Policyholder Soc. Sec.#: ______________________

Policyholder DOB: ______________________

Policy ID#: ______________________

Group ID#: ______________________

Employer: ______________________

Eff. Date: ______________________

Mental Health Phone #: ______________________

Information from Insurance Company:

Are there out patient mental health benefits?	☐ Yes	☐ No	☐ NA
Are there out patient substance abuse benefits?	☐ Yes	☐ No	☐ NA
Is provider in network?	☐ Yes	☐ No	☐ NA
Do they have out of network benefits?	☐ Yes	☐ No	☐ NA

What are the out of network benefits? ______________________

Co-pay/Co-insurance (circle) **Amount** $ ______________________

Deductible Amount $ ______________________

Has it been met?	☐ Yes	☐ No	☐ NA

Are *Authorizations* required for a:

Intake	☐ Yes	☐ No	☐ NA
Ongoing therapy	☐ Yes	☐ No	☐ NA

When? ______________________

Authorization Number # ______________________

How many visits are approved? # ______________________

Authorization Start Date: ______________________

Authorization End Date: ______________________

How many visits per year allowed? # ______________________

<u>NOTES</u>:

Center for Interpersonal Effectiveness, PC

2525 N. Ankeny Blvd. Suite 113 • Ankeny, IA 50021
515-289-9136 515-289-9139 (Fax)

REFERRED By: ______________________________

Reason for Referral: ______________________________

Have you received mental health treatment before? ☐ Yes ☐ No
If so, when and where ______________________________

Do you use: ☐ Tobacco? ☐ Alcohol? ☐ Non-prescription drugs?

Have you been treated for alcohol/drug problems before? ☐ Yes ☐ No
If so, when and where ______________________________

Please check any of the following that you have experienced recently:

☐ Depression	☐ Anxiety	☐ Sleep disturbance	☐ Suicidal thoughts
☐ Panic attacks	☐ Paranoia	☐ Appetite problems	☐ Stealing
☐ Compulsive behaviors	☐ Weight loss/gain	☐ Racing thoughts	☐ High Energy
☐ Low energy	☐ Poor attention	☐ Social withdrawal	☐ Anger/irritability
☐ Distractibility	☐ Aggression	☐ Poor concentration	☐ Blackouts
☐ Hyperactivity	☐ Memory problems	☐ Other(s) ______	

FAMILY/HOME INFORMATION: List people living in the home:

Name	Age	Relationship to client

MEDICAL/HEALTH INFORMATION

Do you have any current or ongoing medical problems? ☐ Yes ☐ No
If so, please explain: ______________________________

Who is your primary doctor/medical provider?

Name	*City*	*Phone number*

What medications do you take? Include non-prescription, herbal medicines and supplements.

Medicine	Dose	Frequency	Who prescribes

Please list any allergies, including medication allergies/sensitivities:

____