INSURANCE VERIFICATION FORM

Client's Name: ____ DOB: ____________________

Client's Address: ____

Policy Holder's Name: ___________________________________ DOB: ___________________

Policy Holder's Address: ____

Insurance Company: ____________________________________ Ph. #: ____________________

Member ID: ____ Group #: __________________

Compassionate Souls Counseling
Alison Garcia
101 Timberlachen Cir
Lake Mary, FL 32746

Is considered Out-of- Network: _____ or In-Network: _________

Effective Date: __________________

Insurance Covers: ________ % with a _________ % co-insurance

Indiv. Ded. $ ____________ Met: $ ______________ Fam. Ded. $ _________ Met: $ _______ Amount due at time of Visit: _____________

Claims Address: ____

Insurance Payor ID: ________________ Representative: ______________________________

Pre-Certification Toll Free Number: ____

Authorization Info: ____

Compassionate Souls Counseling

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