ATLANTA BEHAVIORAL & COGNITIVE SOLUTIONS

Autism Services Insurance Verification Request

Today's Date:	Requesting Site:	Rendering Provider:

PATIENT INFORMATION

Child's Name: (first/last)		Parent/Guardian:
Phone Number:		DOB: Gender: M or F
Street Address:		City/State/Zip:
Diagnosis:	Services Requested:	Diagnosing Physician:
Date of Diagnosis:		Diagnosing Physician Contact:
Primary Care Physician:		Primary Care Physician Contact:

INSURANCE INFORMATION

Primary insurance: **__New Insurance __ Old Insurance __Termed Date __ /__/__**

Subscriber's name:	Birth date:	
Subscriber's S.S. no.:	Policy no:	Group No:
Subscriber's Address:		
Employer:		
Patient's relationship to subscriber:		

Secondary insurance:

Subscriber's name:	Birth date:	
Subscriber's S.S. no.:	Policy no:	Group No:
Subscriber's Address:		
Employer:		
Patient's relationship to subscriber:		

PLEASE INCLUDE A COPY OF THE FRONT AND BACK OF YOUR INSURANCE CARD

Financially Responsible Name:	Phone Number:
Address:	

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize [Name of Practice] or insurance company to release any information required to process my claims

Patient/Guardian signature	Date