Patient Information

Verification Date:		Birth Date	
Therapist		Appointment Date	
Client name		Phone Number:	
Client Address			
Insurance Company		HMO/PPO:	
Insurance ID:		Group Number	
Insurance Phone Number:		Spoke With:	
Effective Date:		Renewal Date:	
Claims Mailing Address:			

Coverage and Filing

In/Out of Network:			
Deductible:		MET-to-date:	
Copay and/or Coinsurance:			
Amount Due from Client:		Max Allowed Visits:	
Treatment Plan:		Authorization:	
Notes:			