



## INSURANCE AUTHORIZATION VERIFICATION FORM

(please answer these questions to the best of your knowledge)

Client's name: \_\_\_\_\_ Date of birth: \_\_\_\_\_

Copay: \_\_\_\_\_ Deductible: \_\_\_\_\_ Deductible remaining: \_\_\_\_\_

Primary Insurance: \_\_\_\_\_

Authorizing (secondary insurance company): \_\_\_\_\_

Precertification needed: yes \_\_\_ no

Authorization number: \_\_\_\_\_

No of visits approved per year: \_\_\_\_\_ No. of visits for this authorization period: \_\_\_\_\_

Start date for authorization: \_\_\_\_\_ End date: \_\_\_\_\_

**(this portion is to be completed by your therapist)**

Diagnosis: \_\_\_\_\_ CPT codes allowed: \_\_\_\_\_

No.	date	code	time	Goal of session	Method of treatment	paid	Mode of payment
1							
2							
3							
4							
5							
6							
7							
8							
9							
10							

Authorization number: \_\_\_\_\_

No of visits approved per year: \_\_\_\_\_ No. of visits for this authorization period: \_\_\_\_\_

Start date for authorization: \_\_\_\_\_ End date: \_\_\_\_\_

No.	date	code	time	Goal of session	Method of treatment	paid	Mode of payment
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