INSURANCE VERIFICATION- MENTAL HEALTH BENEFITS

Caroline Plummer M.S. , LMHC
LH 60193567
1015 1st Ave West Seattle, WA 98119
(206) 914-0154

Date _____

Subscriber's Name_____Date of Birth _____

Client's Name _____ Date of Birth _____

Client's Phone Number _____

Insurance Company _____

Policy/Group# _____

Subscriber ID # from card _____

Customer Service Phone # _____

In Network Mental Health Benefits:

_____

_____

Out of Network Mental Health Benefits:

_____

_____

Annual deductible is $ _____

How much used to date? _____

Copay _____

Preauthorization required? _____

Provider Name _____

Tax ID# _____

Notes: _____

_____

I_____, authorize Caroline Plummer to obtain my mental health benefits and payment from my insurance company. I am aware that this is a quote of benefits and not a guarantee of payment. If my insurance does not provide payment for the services I receive from Caroline Plummer, or if there is a discrepancy in the quoted benefits, I will assume responsibility for all payment owed. For further questions in regards to my benefits, I understand it is my responsibility to confirm quotes and benefits from my insurance company.

_____ _____

Client's Signature ***Date***