Tamara Bush Allen LLC

Tamara Allen Bush, LPC-S, NCC, CSAT

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Insurance Benefit Verification

Date: ______________________________ Verification:______________________

Patient Name: ____________________ DOB: ____________________________

Insured's Name: __________________ DOB: ____________________________

Relationship: ____________________ Employer: ________________________

Insurance Carrier: ________________ Primary/Secondary: ________________

Mental Health Benefits Carrier: ____

Phone: ________________________ Fax: _____________________________

Subscriber ID: ____

Group#: ____

Effective Date: ____

Copay: ____

Deductible: _______________________ Amount Met: ____________________

Benefits: payable: ____

Visits per calendar year: ________________ Used to Date? Y N How many:____

Precert/Authorization Required: __________ Precert/Auth#: _______________

OTR: ______ #Visits: ___________ Effective Dates: _______________

Reference name/#: ____

NOTES: ____