Circle City ABA

A Passion for Progress. Founded in Play.

AUTISM SERVICES INSURANCE VERIFICATION REQUEST

Today's Date: _____ Requesting Site: _____ Rending Provider: _____

PATIENT INFORMATION

Child's Name (first, last)	Parent/Guardian	
Phone Number	DOB	Gender
Street Address	City/State/Zip	
Diagnosis	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 Circle City ABA or insurance company to release any information required to process my claims

Parent/Guardian Signature	Date

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