



ABA THERAPY SERVICES INSURANCE VERIFICATION REQUEST

Today's Date:

Preferred Location:

Supervising Provider (in office only):

PATIENT INFORMATION

Patient's First Name	Middle Name	Last Name
Gender		Patient's DOB
Parent/Guardian(s)		
Email		Phone Number
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 Name

Subscriber Name	Subscriber DOB
Status	Subscriber's S.S. Number
Insured ID/Subscriber ID	Group Number
Subscriber's Address	
Patient's Relationship to Subscriber	

Secondary Insurance Name

Subscriber Name	Subscriber DOB
Status	Subscriber's S.S. Number
Insured ID/Subscriber ID	Group Number
Subscriber's Address	
Patient's Relationship to Subscriber	

PLEASE INCLUDE A COPY OF THE FRONT AND BACK OF YOUR INSURANCE CARD(S)

The above information is accurate to the best of my knowledge. I authorize my insurance benefits to be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Circle City ABA or the insurance company to release any information required to process my claims.

Parent/Guardian/Guarantor Signature

Date