Germantown Psychological Associates, P.C.

7516 Enterprise Avenue, Suite 1
Germantown, TN 38138
Tel: 901-755-5802
Fax: 901-757-2249

DATE: __ / __ / ____

Insurance Verification INFORMATION

***** BRING THIS COMPLETED FORM AND YOUR INSURANCE CARD TO YOUR FIRST VISIT**

1. **Look on the back of your insurance card for the phone number to call to get benefits information.**
2. **When you call the insurance company, you will need to ask for benefits related to "Outpatient Mental Health."**
3. **If prior authorization is required for your first appointment, it is your responsibility to obtain this authorization number before arriving for your appointment.**
4. **We will not be able to file your insurance unless you bring your card and this completed form to your first appointment.**
5. **We do not accept UHC, UBH, UMR, Optum, Humana or Lifesynch. If your benefits are administered through any of these companies, you will be considered a cash patient. If you have any questions, please call our office at (901) 755-5802.**

PRIMARY INSURANCE INFORMATION

Patient's Legal Name: _____DOB:____/____/____
First Name **MI** **Last Name**

Insurance Company: _____Phone # (_____)_____

Subscriber/Policy/ID #: _____ Group #: _____

Policy Holder's Name:_____DOB:_____/_____/_____

Policy Holder's Employer:_____SS#_____-_____-_____

Is _____ "In Network" **and** covered by my policy? Yes No
(The clinician's name that I/my child will be seeing)

We **do not accept** UHC, UBH, Optum, UMR, Humana, or Lifesynch

Who are my mental health benefits administered through?_____

Deductible:$_____ Amount already met this year:$_____Co-pay$_____

Authorization #:_____ EAP#:_____

Start date of authorization:____/____/____Expiration date:____/____/____ # visits authorized:____

Do I have an HRA/HSA? Yes No If yes, what is the current balance? $_____
[HRA – Health Reimbursement Account/HSA – Health Savings Account/FSA - Flexible Spending Account]

Do I need to do Coordination of Benefits?: YES NO If yes, has this been done? YES NO
Name of person you spoke with:_____

Use other side for those with **SECONDARY INSURANCE POLICY**

SECONDARY INSURANCE INFORMATION

Insurance Company: _____ Phone #: (_____)_____

Subscriber/Policy/ID #: _____ Group #: _____

Policy Holder's Name:_____DOB:_____/_____/_____

Policy Holder's Employer:_____ SS#:_____-_____-_____

Is _____ "In Network" **and** covered by my policy? Yes No
(The clinician's name that I/my child will be seeing)

Who are my mental health benefits administered through?_____

We **do not accept** UHC, UBH, UMR, Optum, Humana, or Lifesynch

Deductible:$_____ Amount already met this year:$_____Co-pay:$_____

Authorization #:_____ EAP#:_____

Start date of authorization:____/____/____Expiration date:____/____/____ # visits authorized:____

Do I have an HRA/HSA/FSA? Yes No If yes, what is the current balance? $_____
[HRA – Health Reimbursement Account/HSA – Health Savings Account/FSA - Flexible Spending Account]

Do I need to do Coordination of Benefits?: YES NO If yes, has this been done? YES NO

Name of person you spoke with:_____