Linda M. Sutton, MA LCPC,
16335 So Harlem Ave. Suite #426 Tinley, Park, IL 60477

INSURANCE INFORMATION AND VERIFICATION OF BENEFITS

Client's name_____D.O.B._____

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Insurance Company_____

Mental Health Outpatient Company_____

Number to verify benefits_____

Information from:_____Date_____

****
Primary Insured_____
Employer_____

I.D.# or Soc.Sec.#_____
Policy #_____
Group #_____
Birth Date_____
Client Name _____
Birth Date _____
****
Effective Date of Policy_____
Max Payable Per Session_____ Dr.'s Referral needed_____
Percent Coverage_____
Max Payable per calendar year_____
****
Number for Precert_____
Precertification ID #_____
Certified by_____
Managed Care Company_____
# of Sessions Authorized_____
Patient Co-pay_____
****
CLAIMS SENT TO;

Insurance Forms:
Company Forms_____
Standard CMS1500_____
Electronic Claims

NOTES;_____
_____