AMERICAN
PSYCHIATRIC GROUP

INSURANCE VERIFICATION FORM

Patient Name(First, Last): _____ D.O.B: _____

Address: _____

Phone Number: _____ Email Address: _____

IF YOU DO NOT HAVE INSURANCE, PLEASE INFORM THE ADMIN STAFF

POLICY HOLDER INFORMATION:

Complete the following if you are not the policyholder for your primary insurance:

Policyholder Name: _____

Policy Holder Date of Birth: _____

Policyholder Social Security Number: _____

Policyholder Relationship(Spouse, Child, Parent, Other):_____

PRIMARY INSURANCE

Primary Insurance Company:_____

Group #:_____ ID #:_____

Primary Insurance Type: ☐HMO ☐PPO ☐Medicare ☐Medicaid ☐Other:_____

SECONDARY INSURANCE

Secondary Insurance Company:_____

Group #:_____ ID #:_____

Secondary Insurance Type: ☐HMO ☐PPO ☐Medicare ☐Medicaid ☐Other: _____

PATIENT:_____DATE:_____

GUARDIAN SIGNATURE: _____DATE:_____