Special Therapies, Inc.

Assisting Development and Wellness Throughout the Lifespan

INSURANCE VERTIFICATION FORM

Patient Name: _____ Date of Birth: _____

Parent/Guardian name: _____

Address: _____

City: _____ State: _____ Zip: _____

Home phone: _____ Cell phone: _____ Other phone: _____

E-mail address: _____

PRIMARY INSURANCE CARRIER: _____

Insurance Address: _____

City: _____ State: _____ Zip: _____

Insurance Telephone Number: _____

Subscriber's Name (policy holder): _____

Subscriber's Date of Birth: _____ Subscriber's SS#: _____

Subscriber's Employer: _____

Subscriber/Member Number: _____

Group Number: _____

Special Therapies is not a contracted provider with any insurance carrier. Therefore, payment is due at the time of service. If requested, we will submit claims on your behalf. If payment is approved by your insurance carrier, the allowed amount will be applied towards your out-of-network deductible. Many insurance companies have fixed allowances or percentages based upon your contract with them. Your insurance is a method for you to receive reimbursement for fees for services rendered to you and your dependent(s) by Special Therapies, Inc. Having insurance is not a substitute, nor a guarantee of payment. We do not accept assignment, therefore any reimbursement from your insurance company will be sent directly to you.

I understand and attest that I have obtained information about my insurance coverage for the services I am seeking from Special Therapies, Inc. I am aware of my responsibility for payment of services and deductibles that are incurred.

I authorize Special Therapies, Inc. to submit claims on my / my child's behalf.

Signature: _____ **Date**: _____