Insurance Verification Form

This form is HIPAA protected. Please fill out the highlighted information and email it to: inneractionsiop@gmail.com or fax it to our secure fax at: 855-844-9187. You will receive a call or email to confirm our receipt of the information and we will check your benefits immediately. Please indicate at the space provided at below, how you would like to be notified and your relationship to the patient.

Thank you for inquiring about inneractions, Intensive Outpatient Program.

		Date:

Patient Personal Information:

Patient Name:	*Sex:* **Male ☐ Female ☐**	*Date of Birth:*	*SS #:*
Client Address: *(associated with insurance card)*	*City:*	*State:*	*Zip Code:*
Telephone Number:	*Alternate Telephone Number:*		*Alternate Telephone Number:*

Patient Insurance Information:

Subscriber Name:	*Subscriber SS#:*	*Date of Birth:*	*Telephone Number:*
Subscriber Address:	*City:*	*State:*	*Zip Code:*
Insurance Company/Plan Type:	*Insurance Telephone Number:*	*Group #:*	*Identification # :*

If possible, please include a copy (front/back) of the insurance card.

Please let us know how you would like to be notified and your relationship to the patient:

Telephone number:_____

Email:_____

Relationship to patient:_____

Thank you again for contacting inneractions, IOP