Counseling And Support Associates, PC
AT LAKE NORMAN

INSURANCE INFORMATION AND VERIFICATION OF BENEFITS

Client's name____ D.O.B.__________________

Insurance Company ____

Mental Health Outpatient Company ____

Phone number to verify benefits____

Information from: ____ Date__________________

Primary Insured____

Employer____

I.D.# or Soc.Sec.# ____

Policy #____

Group # ____

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:

NOTES: ____

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18515 Statesville Road #C-01, Cornelius NC 28031 :: 1835 Davie Avenue, Suite 411, Statesville, NC 28677
O 704.892.5339 F 704.892.5939 www.CASAatLKN.com