# Screening Form and Insurance Authorization Form

Name of insurance provider: _____ Plan name:_____

Customer Service #_____ Policy holders name:_____

Intended clients name:_____

Policy holder/ intended client relationship:_____

Intended client's DOB: _____ Policy holder's DOB: _____

Policy holder's Employer_____

Ins. ID # _____ Group # _____

Claims Address: _____

## Call to insurance company

Date insurance company was called: _____

Person you spoke to:_____

Effective date of coverage: _____ Date that plan year starts over:_____

Will this visit be **In network** or **Out of network?**

Is there a deductible to meet?_____ If yes, how much? $_____ Amount met to date:_____

Is there a co-pay?_____ If yes, how much? _____

Limit to the number of sessions per year?_____ If yes, how many? _____

Pre-authorization needed?_____ If yes, has authorization been received?_____

For how many visits?_____ Authorization #_____

## ***Always ask if you have Employee Assistance Program benefits*****

Are there any EAP sessions available?_____ If yes, how many sessions per calendar year? _____

Authorization #: _____