ACA Insurance Verification

Please complete the top part of this form and fax it into ACA at 214-509-6887 or email it to your therapist ASAP with a copy of the front and back of your insurance card. We encourage you to read on website regarding using insurance.

Therapist Name: _____

Insurance Carrier: _____

Insured Name: _____ (Relationship to Pt:_____)

Patient Name: _____

DOB of Insured: _____ DOB of Patient: _____

Insured's Employer: _____

SS# of Insured: _____

Group # _____ Policy/Plan # _____

Phone # for Benefits: _____

Insurance Plan: PPO HMO Other: _____

Date: _____ Spoke to: _____

Effective Date of Policy: _____ Pre-existing Clause? _____

Provider In Network? Y N Out of Network Benefits available? Y N

Copay Amount: $_____ Insurance Pays: _____%

Deductible: $_____ Amount Met: $_____

Family Ded: _____ Amt. Met: _____ Max Visits: _____

Therapies Covered: Individual Group Family Marital

Precertification Required for Outpatient services? Y N

Percert. Phone #: _____
Spoke to: _____ Date: _____ Time: _____
Authorization #: _____
_____Visits Authorized from _____ to _____ Update on: _____

Electronic ID Name: _____
For example Cigna PPO or Cigna Behavioral. All BlueCross is same.