CLIENT INSURANCE VERIFICATION FORM

Today's Date:_________

Client Name____ DOB _______________ SSN_____________________

Address ____

Home Phone:______________________ Work Phone ____________________ Cell Phone ____________________

Insured Name____________________________ Insured's Employer___________________________________

Insured's Address (if different)____

Insured's SSN & DOB ________________

Insurance Company______________________________ Mental Health Insurance__________________________

Client Insurance ID#___________________________ Insurance Phone ___________________________________

Please complete this form and fax to Denise Candidi, LPC at 610.279.2375