Caroline Paltin, Ph.D.

Licensed Psychologist # PSY 14274

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**Insurance Verification**

**STEP 1: Please also fill this section in BEFORE you call the insurance company.**

Name of Insured \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship to Client \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client’s Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance Company \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mailing Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Billing** Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City \_\_\_\_\_\_\_\_\_\_\_\_\_\_ State \_\_\_\_Zip \_\_\_\_\_\_\_ **City \_\_\_\_\_\_\_\_\_\_\_\_\_\_ State \_\_\_\_Zip \_\_\_\_\_\_\_**

Policy # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Group # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**STEP 2: You are responsible to CALL YOUR INSURANCE COMPANY TO OBTAIN THE FOLLOWING INFORMATION. *(Sometimes you have to ask them to slow down so you can write down all the information.)***

Contact Person \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Ext.\_\_\_\_\_\_\_ Fax \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date/1st Contact\_\_\_\_\_\_\_\_\_\_\_\_

1. Is there mental health coverage? Yes No

What type of coverage? Outpatient ( ) Testing ( ) Group ( ) Family ( )

**2. When checking provider lists look for Caroline Paltin, Ph.D.**

3. Is there a deductible? Yes No $\_\_\_\_\_\_\_\_\_\_\_\_\_ per year

4. Coverage details:

\_\_\_\_\_\_\_\_\_% covered $ \_\_\_\_\_\_\_\_\_\_\_ Maximum fee per session

Maximum benefit: $\_\_\_\_\_\_\_\_\_\_\_\_per\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**OR**

#\_\_\_\_\_\_\_\_\_\_\_ sessions per \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Used to date: $ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ or # of sessions \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Renewal date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other information: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

STEP 3: Is this a change in insurance coverage since you began seeing Dr. Paltin? \_\_ YES \_\_NO

If so, what is the effective Date of the new Insurance (What date should we begin billing this plan)? \_\_\_\_\_\_\_\_\_\_\_ 20\_\_\_\_