Speech-Language Pathology Services, LLC | 1012 Marquez Place, Suite 211 Santa Fe, NM 87505 | 505.302.0095

Health Insurance Verification Form

Patient Name: Date of Birth:
Primary Insurance: Phone Number:
☐ In Network ☐ Out of Network
Member Name: Employer:
Member ID #: Group Number#
Effective Date: / /
Is pre-authorization required? ☐ Yes ☐ No
Co-Pay Amount: $
Deductible: Individual: $ Family: $ Out of Pocket Max: $
Progress Towards Deductible to Date: $
Number of visits allowed:
Coverage for therapy services:

Additional details / documents needed:

Secondary Insurance (if applicable): Phone Number:
☐ In Network ☐ Out of Network
Member Name: Employer:
Member ID #: Group Number#
Effective Date: / /
Is pre-authorization required? ☐ Yes ☐ No
Co-Pay Amount: $
Deductible: Individual: $ Family: $ Out of Pocket Max: $
Progress Towards Deductible to Date: $
Number of visits allowed:
Coverage for therapy services:

Additional details / documents needed:

Insurance Company Spoken With: ☐Primary Insurance ☐Secondary Insurance
Authorization Number:
Call Reference Number:
Date and Time of Call:
Person Spoke With: