Williamsville Wellness
Insurance Verification Form

Date: ____________________ Person taking info: ____________________________________

Patient Name: ____

DOB:____________________________ SSN: ____

Address: ____

City: ____________________________State: _____________________Zip:_______________________

Phone: _________________________________Cell Phone: ____________________________________

Addiction: Gambling _______ Alcohol _____Drugs: ____

Insurance Company: __________________________________Effective Date: ___________________

Policy ID#:______________________________Group #:____

Policy Holder Name:_____________________SSN:_______________________DOB:______________

BH/SA Insurance Phone #: ____

Contact Name:_____________BH/SA Managed by:_____________________Phone:_____________

Does patient have MH/SA Coverage: ( ) Y ( ) N Effective Date:_________________________

Patient need Auth for individual: ( ) Y ( ) N Patient need Auth for group: ( ) Y ( ) N

Deductible amount:________________ ( ) Per Cal yr ( ) Per Ins yr Copay:______________

Met for yr:________________# visits per yr:_____________BH/SA Phone:____________________

Benefits for Residential Coverage:____

Benefits for Partial Coverage:____

Room & Board included in Partial: ( ) Y ( ) N Additional Info:________________________

Claims Address: ____

Previous treatment: ____

Returned Call: _________________________________