Mental Health Insurance Verification Form – Group Services

Client Information

Field	Details
Client Name	_____
Date of Birth	____ / ____ / _____
Phone Number	(_____) _____ – _____
Email Address	_____
Address	_____
City / State / ZIP	_____

Insurance Information

Field	Details
Primary Insurance Company	_____
Phone Number (Provider Line)	(_____) _____ – _____
Member ID / Policy Number	_____
Group Number	_____
Subscriber Name	_____

Subscriber Date of Birth ____ / ____ / _____

Relationship to Client ☐ Self ☐ Spouse ☐ Parent ☐ Other: _____

This form is provided as a courtesy to help verify your mental health insurance benefits and does not guarantee coverage or payment. We recommend you contact your insurance provider directly for the most accurate and up-to-date information.Please email completed form to Arianna Gonzalez at therapygonzalez@gmail.com