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Boca Raton, FL 33432
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Insurance Verification Form

Date: _____

Client Name: _____ D.O.B. _____

Insured's Name: _____ Relation: _____

Address: _____ Phone: _____

Insurance Company: _____

Billing Address: _____ Phone: _____

Employer: _____

Member I.D. #: _____ Effective Date: _____

of Sessions: _____ Deductible: _____

Teletherapy coverage: Yes/No

Co-pay _____

Authorization Needed: Yes/No

NOTES:

