Restoring Hope, Health, and Serenity

Serenity Point Counseling
312 Chestnut Street Suite 113
Meadville, PA 16335
Phone (814)795-4034
Fax (814) 724-7495

INSURANCE VERIFICATION FORM

Patient Name: ____________________________________ Patient Date of Birth: ________________________

Patient SSN: ______________________________________ Phone Number: _____________________________

Address: ____

Primary Insured: Policy Holder or Subscriber

Primary Insured Name: ____________________________________ Primary DOB: _______________________

Primary SSN: ______________________________________

Employer: ____

Insurance Company: ____

Plan Name or Coverage Type: ______________________________________

Member ID/Policy Number: ____

Group ID/Number: ____

Effective Date (if known): ____

Customer Service/Provider Services # (on back of card): ___________________________________

I authorize Serenity Point Counseling the use of the above information for the purpose of obtaining third party/insurance reimbursement on behalf of the primary insured and primary patient.

____ ____________________________________
Patient/Guardian Signature Date