Eligibility Request

Please include copy of front and back of insurance card

Date of Request: _____

Patient Legal Name: _____

Date of Birth: _____

Patient Address: _____

Primary Insurance: _____

Insurance ID Number: _____

Insurance Group Number: _____

Insurance Phone: _____ Supervising BCBA: _____

Subscriber Name: _____

Subscriber Date of Birth: _____

Best Contact Phone Number: _____

Is the Subscribers Address the Same as the Patient? Yes _____ No_____

If no, what is the Subscriber's Address? _____

_____

Email address: _____

Secondary Insurance: _____

Diagnosis Code: _____

Initial Diagnosing Doctor and Date Diagnosed:_____

Projected Date Patient has/will be seen (if any): _____

Any Additional Notes: _____

How did you hear about us? _____

****** *Please Complete Highlighted Areas Only*******