young mind center

INSURANCE VERIFICATION FORM

Child's Name: _____ DOB: _____

Policy Holder Name: _____ DOB: _____

Policy Holder's Address: _____

Policy Holder's Phone Number: _____

Insurance Carrier: _____

Provider Services Phone Number: _____
Include number for behavioral health if provided

Insurance Billing Address: _____

Member ID: _____ Group #: _____

Policy Holder's Employer (if applicable): _____

Group Plan Name: _____

The Young Mind Center has permission to contact my insurance carrier named above and discuss my coverage and services to be provided.

I understand that it is my responsibility to understand my insurance benefits. _____ Initial

I acknowledge that I am financially responsible for any and all charges not covered by my insurance carrier. _____ Initial

I HAVE READ, UNDERSTAND, AND ACCEPT THE CONDITIONS NOTED ABOVE.

PARENT/GUARDIAN SIGNATURE DATE

YMC REPRESENTATIVE SIGNATURE DATE