Verified By: _____ Date: ____/____/____

Insurance Verification Information

Patient Name: _____ DOB: ____/_____/_____
Patient Address: _____ Phone: _(____)____-_____
Patient SS#: _____-_____-_____
Primary Insurance Company: _____ Insurance Phone: _(____)____-_____
Group #:_____ Policy #:_____ Plan Type:_____
Policy Holder's Name:_____D.O.B.:____/_____/_____SS#:_____-_____-_____
Employer: _____
Patient's Relationship to Policy Holder: _____

Secondary Insurance Company: _____ Insurance Phone: _(____)____-_____
Group #:_____ Policy #:_____ Plan Type:_____
Policy Holder's Name:_____D.O.B.:____/_____/_____SS#:_____-_____-_____
Employer: _____
Patient's Relationship to Policy Holder: _____

I _____ (policy holder's name), give my consent to *Therapy Center of Acadiana, LLC* to contact the above insurance carrier in order to determine the type and amount of funding that may be available for ABA services.

Signature: _____ Date: ____/_____/_____
(Policy Holder)

The above information is true to the best of my knowledge. I authorize Therapy Center of Acadiana, LLC to provide the patient or myself with reasonable and proper medical care according to today's standards. I authorize the insurance company or any third party payer to pay any benefits due directly to this office should they accept assignment of my claim. I also authorize Therapy Center of Acadiana, LLC or the insurance company to release any information required to process my claims.
I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR THE ACCOUNT EVEN THOUGH INSURANCE MAY BE PENDING ON ALL OR A PORTION OF THE CHARGES.

Therapy Center of Acadiana, LLC, 300 Park West Dr. Scott, LA 70583
TCAcadiana@yahoo.com
Phone: 337-233-1167 Fax: 337-233-1168

Verified By: _____ Date: ___/___/___

ELIGIBILITY INFORMATION

(For Office Use Only)

Patient Name: _____ DOB: ___/_____/_____
Policy #: _____
Policy Effective Date: ___/_____/_____ Benefit Period: _____
Copay: $_____ Provider Reimbursement: _____% Patient Pays: _____%
Does the Patient have Deductibles? ☐ Yes ☐ No
Deductible Amount: $_____ Deductible met? ☐Yes ☐ No If no, Remaining: $_____
Does the Patient have Out-Of-Pocket? ☐ Yes ☐ No OOP Max: $_____
OOP Met? ☐ Yes☐ No If no, Remaining: $_____
Coverage for Autism Spectrum Disorder: Is the Patient Covered for ABA Therapy? ☐ Yes ☐ No
Coverage Details:

_____
_____
_____
_____

If not Covered, Why?

_____
_____

Is the Patient covered for Behavior Therapy under Outpatient Mental Health? ☐ Yes ☐ No

Therapy Center of Acadiana
FOR INDIVIDUALS WITH DEVELOPMENTAL DELAYS