**Houston Corporate Speech Pathology, PLLC**
**4660 Beechnut Street**
**Suite 226**
**Houston, TX 77096**
**Phone: (832) 736-5253**
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## Insurance Verification Form

Every insurance policy is different. Policies may change from year to year. Please contact your insurance company to confirm your benefits for the calendar year.

Client Name:_____ Date of Birth:_____
Insurance Company_____
Insurance Phone Number:_____
Dates of Coverage: _____

| | |
|---|---|
| Member Name: | Employer: |
| Member ID #: | Group Number# |
| Effective Date: / / | |

Are benefits shared? OT SLP PT
Do you have a deductible YES NO Amount?_____
Amount of Copay:__ or % of client responsibility__
Is there a maximum amount of sessions? Yes. No
Is physician referral required? Yes. No
Is Preauthorization required? Yes No

If YES: What is the phone number, fax number and contact person's name to acquire preauthorization:_____
____

Are benefits for medical necessity only:
_____