

**SHAUNA NORTON, APRN, PLLC - INSURANCE BENEFITS VERIFICATION FORM**

Complete an insurance verification form for each insurance company you plan to use for your appointment(s).

Please circle one:      Primary Insurance                      Secondary Insurance

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Name of Insurance Company: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Policy Holder Name: \_\_\_\_\_

Identification # \_\_\_\_\_ Group # \_\_\_\_\_

Insurance Person Contacted: \_\_\_\_\_ Date: \_\_\_\_\_

Do I have Outpatient Mental Health Benefits? Yes No  
(If No, stop here, you will be responsible for payment in full at the time of your appointment)

If Yes, is Shauna Norton, Psychiatric APRN, listed as a preferred provider on my plan? Yes No

If No, Do I have Out-of-Network Coverage for Outpatient Mental Health: Yes No  
(if No stop here, you will be responsible for payment in full at the time of your appointment)

*If Shauna Norton, APRN, is listed as a provider or you have out of network coverage please ask the following questions:*

Is there a Yearly Deductible for Outpatient Mental Health: Yes No

Yearly Deductible \$ \_\_\_\_\_ Year to Date Deductible met for this year (if any) \$ \_\_\_\_\_

What is the Patient Co-pay due at the time of the appointment (once yearly deductible is met, if applicable)

\$ \_\_\_\_\_ each visit OR a % \_\_\_\_\_ of each visit

Insurance payments are made directly to:      Patient      Provider

Prior Authorization Required for Outpatient Mental Health Visits: Yes No

Authorization # \_\_\_\_\_ Authorization Valid from \_\_\_\_\_ to \_\_\_\_\_  
Month/Day/Year                      Month/Day/Year

Number of Visits Authorized: \_\_\_\_\_ Number of Visits Already Used \_\_\_\_\_

**I have verified insurance benefits for my appointment. By signing below I assume financial responsibility for services provided by Shauna Norton, APRN.**

\_\_\_\_\_  
**Signature of Patient or Person Assuming Financial Responsibility**                      **Date**