SHAUNA NORTON, ANP, LLC - 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: __________________________

Policy Holder Name: __________________________ DOB: __________________________

Identification # _________________________ Group # _________________________________

Name of Insurance Company: _________________________ Phone Number: __________________

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 ANP, listed as a 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, ANP, is listed as a provider or you have out of network coverage please ask the following questions:

Does my coverage have a Yearly Deductible for Outpatient Mental Health: Yes No

If yes, what month does my new deductible year begin? Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec

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, ANP, LLC.

____ ______________________

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