Family Counseling Center
Client Insurance Verification Form

Client's Name:_____ **Date:**_____ **DOB:**_____

Client's Primary Insurance Co._____

Primary Insurance Phone Number:_____

Policy Number:_____ **Group Number:**_____

Subscribers Name:_____ **Subscribers Date of Birth:**_____

Relationship to Client:_____

Effective Date of Coverage:_____

Coverage Terminated: □ Y □ N **Date of Termination:**_____

In Network Copay_____ **Deductible**_____ **Met** □Y □N_____

Out of Network Coverage: □ Y □ N **INS Coverage**_____ **Client Resp.**_____

Secondary Insurance Name:_____

Secondary Insurance Phone Number:_____

Policy Number:_____ **Group Number:**_____

Subscribers Name:_____ **Date of Birth:**_____

Relationship to Client:_____

(Updated December, 2015)