New Client Telephone Intake

Provider Name: _____ In-Network: _____ Out-of-Network: _____

Today's Date: _____ Date and Time of Appt: _____

Client's Name: _____Client's D/O/B: _____

Responsible Party Home Phone Number: _____Cell Number: _____

Is it ok to leave message at these numbers: Home ❑ Yes ❑ No Cell: ❑ Yes ❑ No

Email _____

Mailing Address: _____

Name of Insured: _____SSN of Insured: _____ DOB Insured: _____

ID# from Card: _____ Group #: _____

Primary Insurance Co Name: _____ Benefits/Eligibility Phone: _____

Precertification Phone: _____

Secondary Insurance Co Name: _____ Benefits/Eligibility Phone: _____

Precertification Phone: _____

Will client be utilizing EAP Benefits? _____ EAP Co: _____ EAP Phone: _____

Other Info: _____

_____

Benefit Information:

Pre-existing/Exclusionary Riders: _____

Policy Effective Date: _____Calendar Year or Plan Year: _____

MH Ded: _____ Ded Met:_____ OOP: _____OOP Met:_____

Collect until Ded Met:_____

Collect After Ded Met: _____Co-pay or Co-ins:_____

Auth Required: _____ Visits per year: _____ Visits Used Current year: _____

If Auth Required:

Managed by: _____ Phone #_____Fax # for OTR's:_____

Authorization #: _____ Date Start: _____ End: _____Visits Auth: _____

Address for Claims: _____

EAP Benefits Available: _____ 1500/Special Forms/Special CPT code: _____

Authorization #: _____ Date Start: _____ End: _____Visits Auth: _____

Address for EAP Claims:_____

Contact at Insurance Co: _____Verified by: _____Date:_____

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