INSURANCE BENEFIT QUESTIONNAIRE

Provider: Scott M. Turner LMSW, CADC NPI #: 1912235391

Client name

Client date of birth

Name of Insurance Company

Contract/Policy/ID#

Group/Acct #

Subscriber

Subscriber date of birth

Client's relationship to Subscriber

____self ____spouse ____child ____other

Insurance Company Phone #

Name of representative you spoke to

Ask: Is Scott in my network? ____yes	____no
What % of the visit does my ins cover?	
How many visits are covered?	
What is my co-pay per visit?	
What is my deductible per plan year?	
What is my remaining deductible?	
Dates of Policy Period / Plan Year	

I understand that it is my responsibility to verify insurance benefits for myself and/or my dependents, and I will provide this information to Turner Therapy LLC. I further understand that I am financially responsible for any charges not covered by my insurance carrier.

Printed name of client or parent/guardian of minor

Date:

Signature of client or parent/guardian of minor