Lovaas Institute

Provider Request for

MEDICAL BENEFITS & ELIGIBILITY VERIFICATION

Please list the insurance information for any and all policies covering your child. Include a copy of the front and back of the patient's insurance card with this form.

Email to: info@lovaas.com

Patient Information:

Patient Name: _____

Parents/Guardians: _____

Patient D.O.B. _____ Patient SS# _____

Patient Address: _____

Phone: _____ Email: _____

Plan 1 *(include a copy of front and back of card)*

Insurance Company: _____ Phone: _____

Group No.: _____ Policy No.:_____ Plan Type:_____

Policy Holder's Name: _____D.O.B._____SS#_____

Employer_____

I _____ (policy holder's name), give my consent to the Lovaas Institute to contact the above insurance carrier in order to determine the type and amount of funding that may be available for ABA services.

Signature_____ Date _____

(Policy Holder)

Plan 2 *(include a copy of front and back of card)*

Insurance Company: _____ Phone: _____

Group No.: _____ Policy No.:_____ Plan Type:_____

Policy Holder's Name: _____D.O.B._____SS#_____

Employer_____

I _____ (policy holder's name), give my consent to the Lovaas Institute to contact the above insurance carrier in order to determine the type and amount of funding that may be available for ABA services.

Signature_____ Date _____

(Policy Holder)

- If a third plan exists, please duplicate this page.

ELIGIBILITY INFORMATION

(For Lovaas Institute Use Only)

PRIMARY:

A. Eligibility

Is the patient covered for ABA Therapy?

If not, is patient covered for Behavior Therapy under Outpatient Mental Health?

Yes ⇒ go to section B

No ⇒ Why not? _____

_____

B. Coverage Details: _____

_____

_____

Policy Effective Date**:** _____ Benefit Period: _____

Start date of their calendar year: _____

Copay: $_____ per _____ Co-Insurance: Client Pays: _____% Notes: _____

Is there an annual deductible?

Individual: $_____ Amount met: $_____ Family: $_____ Amount met $_____

Is there an out of pocket max (calendar year max)?

Individual: $_____ Amount met: $_____ Family: $_____ Amount met $_____

C. Authorization

Is Pre-Certification Required? _____Precert Phone# _____Precert Fax# _____

Claim Submission Details: _____

_____

Relationship Rep's Name: _____Inquiry Ref #_____

Additional Notes:

ELIGIBILITY INFORMATION
(For Lovaas Institute Use Only)

SECONDARY:

A. Eligibility
Is the patient covered for ABA Therapy?
If not, is patient covered for Behavior Therapy under Outpatient Mental Health?
Yes ⇒ go to section B
No ⇒ Why not? _____

_____

B. Coverage Details: _____

_____

_____

Policy Effective Date**:** _____ Benefit Period: _____
Start date of their calendar year: _____

Copay: $_____ per _____ Co-Insurance: Client Pays: _____% Notes: _____

Is there an annual deductible?
Individual: $_____ Amount met: $_____ Family: $_____ Amount met $_____

Is there an out of pocket max (calendar year max)?
Individual: $_____ Amount met: $_____ Family: $_____ Amount met $_____

C. Authorization
Is Pre-Certification Required? _____Precert Phone# _____Precert Fax# _____

Claim Submission Details: _____

_____

Relationship Rep's Name: _____Inquiry Ref #_____

Additional Notes: