JUDITH DEGRAZIA HARRINGTON, PH.D., HSPP
Licensed Psychologist | Clinical Neuropsychologist

Indiana – Insurance Information Form

Scheduled W:/____________ Patient Name:____
On:_____________________ Patient Address:____
@:_________ DOB:___________ S.S.#: _________ Referred by:___________________
Home#:__________ Cell#:_________ Work#:_________ Guardian#:_________
Parent/Guardian Name:____

PRIMARY:

Insurance Co.:_________________________________ **Employer:**_______________________
Policy holder name:____________________________ **S.S.#:**__________________________
Policy ID:____________________________________ **Group#:**_________________________
Insurance phone #'s:___________________________ **DOB:**____________________________

PRIMARY VERIFICATION:

Mental Health vendor:____
Claim Address:____

FOR NON-SEVERE

Deductible:__________/cal.yr Met? How Much?___________ Visits allowed/yr:_____
Copay:_______________ Coinsurance:__________ Pre-auth Required?

FOR SEVERE

Deductible:____________ Met? How Much?___________ Visits allowed/yr:_____
Copay:_______________ Coinsurance:__________ Pre-auth Required?
Authorization phone#:___________________________ Authorization#:________ # of sessions:________
Spoke With:____ Date:_______________

SECONDARY:

Insurance Co.:_________________________________ **Employer:**_______________________
Policy holder name:____________________________ **S.S.#:**__________________________
Policy ID:____________________________________ **Group#:**_________________________
Insurance phone #'s:___________________________ **DOB:**____________________________

SECONDARY VERIFICATION:

Mental Health vendor:____
Claim Address:____

FOR NON-SEVERE

Deductible:____________ Met? How Much?___________ Visits allowed/yr:_____
Copay:_______________ Coinsurance:__________ Pre-auth Required?

FOR SEVERE

Deductible:____________ Met? How Much?___________ Visits allowed/yr:_____
Copay:_______________ Coinsurance:__________ Pre-auth Required?
Authorization phone#:___________________________ Authorization#:_________ # of sessions:________
Spoke With Who:____ Date:_______________

INSURANCE VERIFICATION FOR TESTING (DR. HARRINGTON)

Claim Address:____
Deductible:________________/cal.yr. Met?_________ How Much?_________ Coinsurance:___________
Pre-auth required:____________ Authorization phone#:________________ Auth#:______________
# of units:______ Spoke with who:__________________ Date:______________