Learning Solutions LLC

CLIENT INSURANCE INFORMATION FORM

Date Completed: _____

Information provided will be protected in accordance with HIPAA requirements and other applicable confidentiality regulations.
****Learning Solutions does not guarantee that your specific Insurance Policy/Coverage provides authorized benefits for services and/or treatments provided to client(s) by Learning Solutions' Clinicians and Staff.***

Client and Parent/Legal Guardian Information:

Client: First Name _____ **M.I.** _____ **Last Name** _____

Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Home Phone: _____ **Work/Cell Phone:** _____

Social Security # _____-_____-_____ **Birth Date** _______________ **Gender:** M F

List specific diagnosis, condition, or concern which precipitated coming for services/treatment: Y N _____

_____

Date of medical diagnosis or onset of concern: _____

Has there been Hospitalization due to current medical diagnosis or concern: Y N

From _______________ to _______________

Primary Insurance Coverage:

Client/Subscriber Insurance Company: _____

Subscriber Information: Full Name: _____ **Relationship to Client:** _____

Subscriber Address if different than Client: _____

Marital Status: Single Married Other

Employment Status: Full-Time Part-Time Not Employed Student

Subscriber Social Security # _____-_____-_____ **Subscriber Birth Date** _______________

Subscriber Employment Status: Full-Time Part-Time Not Employed Student **Subscriber Gender:** M F

Subscriber Employer Name, Address and Phone Number: _____

_____

ID/Policy #: _____ **Group #:** _____

****Please attach a copy of Client/Subscriber related Insurance Card, and sign authorization below.***

Client/Subscriber or Authorized Person's Signature: ***I authorize payment of medical and/or behavioral health benefits to Learning Solutions, LLC or other information necessary to process this claim or any further claims. I understand I am responsible to pay any fees for service/treatment, and/or charges not provided coverage under my insurance plan.*** **Print:** _____ **Signature:** _____ **Date:** _____

Learning Solutions LLC

Secondary Insurance Coverage, if applicable:

Client/Subscriber Insurance Company: _____

Subscriber Information: Full Name: _____ **Relationship to Client:** _____

Subscriber Address if different than Client: _____

Subscriber Social Security # _____-_____-_____ **Subscriber Birth Date** _______________

Subscriber Employment Status: Full-Time Part-Time Not Employed Student **Subscriber Gender:** M F

Subscriber Employer Name, Address and Phone Number: _____

_____

ID/Policy #: _____ **Group #:** _____

******Please attach a copy of Client/Subscriber related Insurance Card, and sign authorization below.***

Client/Subscriber or Authorized Person's Signature*: I authorize payment of medical and/or behavioral health benefits to Learning Solutions, LLC or other information necessary to process this claim or any further claims. I understand I am responsible to pay any fees for service/treatment, and/or charges not provided coverage under my insurance plan.***Print:** _____**Signature:** _____ **Date:** _____

****

To be completed by Clinician/Staff:

Clinician:_____ Provider Number (NPI#):_____ Lic.#: _____

What Location will Client be Treated/Serviced: 11 Office 99 Community ____ Home ____ School District ____ Other

Client Medical Diagnosis: _____ Medical Documentation/Report Provided on File: Y N

Diagnosis Code(s) _____ _____ _____ _____

Treatment Recommended/Providing: _____

CPT (Procedure) Codes:_____ _____ _____ _____

Prior authorization number (if required):_____

FOR OFFICE USE ONLY:

Insurance Carrier: _____ **# Sessions** _____ **# Remaining**

$_____**Client Co-Pay** **Policy Effective Start Date** _____

$ _____ **% Client** **Policy Effective End Date** _____

$ _____ **% Payment** **Referral:** ☐ **N/A** ☐ **P.C. Physician**

$_____ **% Deductible** ☐ **Met**

$ _____ **Remaining** **Other/Notes:** _____

_____

_____

_____

Authorization: ☐ **None** ☐ **BCBS** ☐ **Cigna** ☐ **Tufts**

☐ **HPHC** ☐ **Optum** ☐ **Aetna** ☐ **UBH** ☐ **NbhoodHealth**

☐ **Other** _____

Authorization #: _____

# of Sessions Authorized: _____ **(# of** _____ **Units)**

☐ **Fee Schedule Unavailable**

Code	Allowed	%Amount	Code	Allowed	%Amount
H2012	$_____	/_____	90834	$_____	/_____
H2019	$_____	/_____	90837	$_____	/_____
H2014	$_____	/_____	90853	$_____	/_____
92507	$_____	/_____	92508	$_____	/_____
_____	$_____	/_____	_____	$_____	/_____