Autism Academy of South Carolina

Insurance Benefit Verification Form

To verify insurance benefits, please complete this form and provide a copy of your primary insurance ID card. Forms may be mailed to our office at PO BOX 7514 Columbia, SC 29202 or faxed to 803-569-1054. Forms should be mailed to the attention of our Business Manager, Shanna Poston. Please allow 3 business days for verification of your insurance.

PATIENT INFORMATION

PATIENT NAME: _____ **DOB (MM/DD/YYYY)** _____

NAME OF GAURDIAN: _____

PATIENT ADDRESS: _____ **CITY** _____ **STATE** _____ **ZIP** _____

PRIMARY PHONE _____ **SECONDARY PHONE** _____

PRIMARY INSURANCE INFORMATION

PRIMARY INSURANCE: Please select one of the options below

☐ BlueCross Blue Shield Plan ☐ BlueChoice Health Plans ☐ State Health Plan

☐ Cigna ☐ Tricare Active Duty ☐ Tricare Retired Military

CARDHOLDER NAME: _____ **RELATIONSHIP TO CARDHOLDER:** _____

CARDHOLDER DOB (MM/DD/YYYY) _____ **PROVIDER ID #** _____

POLICY # _____ **GROUP #** _____

SECONDARY INSURANCE INFORMATION (IF APPLICABLE)

SECONDARY INSURANCE NAME: _____

CARDHOLDER NAME: _____ **RELATIONSHIP TO CARDHOLDER:** _____

CARDHOLDER DOB (MM/DD/YYYY) _____ **PROVIDER ID #** _____

POLICY # _____ **GROUP #** _____

AUTHORIZATION

My signature below certifies that I have read, understand, and agree to the Patient Authorization to release my protected health information to the Autism Academy of South Carolina and companies working on their behalf, including vendors, other affiliates, and other service providers supporting the Autism Academy of SC.

PARENT/GARDIAN NAME: _____ **DATE (MM/DD/YYYY:** _____

PARENT/GARDIAN SIGNATURE: _____