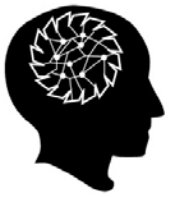


COMPREHENSIVE PSYCHIATRIC CARE

Psychopharmacology & Psychotherapy
Adults, Adolescents, Children & Seniors

INSURANCE POLICIES

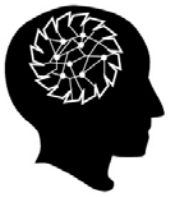
We understand that you wish to use your insurance benefits for our services; however, ultimately *it is your responsibility* to determine whether your doctor is in your network and to be aware of your current Mental Health insurance coverage. It is also necessary for you to obtain an authorization when required by your insurance company.

In order to use your insurance for your upcoming visit, **it is critical to complete the following Patient Insurance Verification form.** You will want to contact your insurance company at the mental health phone number provided to you on your insurance card and ask a representative the following information. **Without this form completed in its entirety, you will default to a "Self-Pay" status and be required to make payment in full at the time of service. We cannot file your insurance claims for you without the information.**

It is YOUR responsibility to inform our office of any changes in your insurance coverage.

Sincerely,

COMPREHENSIVE PSYCHIATRIC CARE



COMPREHENSIVE PSYCHIATRIC CARE

Psychopharmacology & Psychotherapy
Adults, Adolescents, Children & Seniors

Patient Insurance Verification of Benefits Form

(Please Complete in Full)

Name and complete address: Date of Birth: _____

_____ Patient Social Security #: _____

_____ Home Phone: _____

_____

Policy Holder's Name: _____ Policy Holder's DOB: _____

Policy Holder's SS#:_____ Employer: _____

Insurance Company: _____ Mental Health phone #: _____

Policy ID# _____ Group ID# _____ Effective date: _____

Mental Health Claims Address: _____

***Please contact your insurance _____

company for this address, as it may be _____

different than the one on your card ***

MD

Is Dr. Aleem in network? YES/NO Co-pay Amount $ _____

Do you have out of network benefits? YES/NO Deductible Amount$_____Has it been met___

How many visits per year are allowed? #_____

Are authorizations required for a:

90801(new patient) YES/NO

90862(medication management) YES/NO

Authorization # _____ Auth Start Date: _____ Auth End Date: _____

How many visits are approved # _____

Patient Signature: _____ Rep: _____ Date: _____