Insurance Verification

Patient Name: _____ DOB: _____

Insurance Plan: _____

Policy Number/Member ID: _____

(Harmony is not an insurance, we are a 3rd party administrator)

Insured Name: _____DOB: _____

Insured Employer: _____

Mental Health/Substance Abuse

Effective Date: _____ Term Date: _____

Co-Pay: _____ Deductible: _____

Deductible Amount Met: _____

Insurance Representative: _____

Confirmation/Reference #: _____

Date: _____Time: _____

Information Taken By: _____

Send the following form back to Harmony Healthcare along with your request.