Verification of Benefits

The following information is needed to verify Applied Behavior Analysis (ABA) benefits with your insurance provider

Name of Insurance Provider: ____

Name of Child: ____Date of birth: _____________________________

Client address: ____

Member ID card # (if applicable): __________________________ Group or account # on ID card: ____________________

Subscriber name (if different from Client): ____

Subscriber's relationship to customer: ______________________ Subscriber's Date of Birth: _______________________

Subscriber's employer name: ________________________

Subscriber's ID card # (if applicable): ____________________ Group or account # on ID card: ________________

The purpose of this release is: Verification of ABA benefits from insurance provider(s).

I consent to Behavior Central Solutions, Inc. using and/or disclosing my protected health information (PHI) for the verification of ABA eligibility with my insurance provider only. I understand that signing this form does not guarantee or authorize treatment services.

____ ____________________________

Printed Name of Parent/Legal Guardian Relationship to Patient

____ ____________________________

Signature of Parent/Legal Guardian Date

*Our practice is committed ensuring the protection of your PHI. Please let us know if you have any questions or concerns.