Cen-Tex Medical Claims
17113 E. Darleen Dr
Leander, TX 78641

512-267-2614
Fax 512-267-9637

PATIENT NAME:

INSURANCE VERIFICATION

www.centexmedicalclaims.com

EVAL DX

Auth # ☐ AUTH NOT REQ'D Visits Appv'd Dates

CO-PAY:

PATIENT ADDRESS & PHONE#s: OK to LM?

Patient's Name: _____
DOB & SSN: _____
Insured's Name: _____
Insurance ID#: _____
Insurance Company: _____
Group Number: _____
Insurance Co. Phone: _____
Provider's Name: _____
Provider's Tax ID or SSN: _____ Provider network status: IN or OUT _____
NPI: _____ Cur. Ins. Rate: 90791 _____ 90834 _____
90837 _____ 90847 _____

POLICY LIMITATIONS

Effective Date: _____ Policy Year: _____
Annual Deductible: _____ Ded. Met (to date): _____
Percentage Payable - IN-NET: _____ SMI DX: _____
OUT-NET: _____ SMI DX: _____
Precertification Requirements: _____
Pre-Cert Ph #: _____

Other Policy Limitations

Max # of sessions: _____ per year # Used (to date) _____ SMI DX: _____

Max coverage: $_____visit $_____ year $_____Out/Pocket Max--Met_____(to date)

Therapy Covered: EVAL_____ Individual Ther. _____ Family Ther. _____ Group Ther. _____

Other Coverage Notes:

MAILING ADDRESS: _____ PAYOR ID: _____

ID# to use on claims _____ SELF FUNDED: Yes / No

_____

Date Verified: _____ Time Verified: _____ Verified By: _____

Spoke w/ _____ at Ins. Co. _____ Reference # _____

BENEFITS - To Provider on _____ by: PHONE / FAX / EMAIL / COPY @ _____

To Patient/Parent on _____ by: PHONE / EMAIL / LEFT MESSAGE @ _____