River Valley Benefit Verification Form

Please bring this completed checklist with you to your next appointment.

Must be filled out prior to being seen.

Insurance company: _____

Benefits phone number (usually on the back of the insurance card): _____

Billing address for mental health claims: _____

Annual deductible: _____

Calendar year or fiscal year: _____

Amount of deductible already met so far this year: _____

Allowed number of psychological sessions per year (for all disciplines seen): _____

Is pre-authorization required? Yes ☐ No ☐

*If preauthorization is required, authorization number: _____

*Name of person authorizing: _____

Is a doctor's referral required? Yes ☐ No ☐

*Name of doctor and date contacted: _____

Is family therapy covered? Yes ☐ No ☐

If applicable, is psychological testing covered? Yes ☐ No ☐

Mental health co-pay (often different from regular doctor's visit co-pays): _____

Do you have a co-payment? Yes ☐ No ☐

*If yes, co-pay amount: _____

*If no, what % are you responsible for? _____

Is this therapist covered in your company's mental health network? Yes ☐ No ☐

*If no, what are the out of network benefits? _____