David M. Croninger, DMin, LMFT, LADC, CSAT, CMAT

INSURANCE INFORMATION AND VERIFICATION OF BENEFITS

Please complete and bring with you to your first session.

Client's Name___________________________________ D.O.B.__________________________

****

Insurance Company AND ADDRESS TO SEND CLAIMS TO __________________________

____

Phone Number to Verify Benefits____

****

Primary Insured____
Primary Birth Date ____
Primary Employer ____
I.D.# or Soc.Sec.#____
Policy # ____
Group # ____

****

Questions to ask your insurance provider:

1. Do I have mental health benefits? YES or NO
2. How many sessions per calendar year does my plan cover? ___________
3. Is the provider (David M. Croninger) an in-network provider? YES or NO
4. Do I have a deductible? YES or NO
5. If "yes," how much is it? ___________
    a. How much of my deductible have I met? ___________
6. What is my co-pay? ___________
7. Does my plan require precertification? YES or NO
8. Does my plan require approval by a primary care physician? YES or NO
9. Preauthorization Number (if needed) ___________

****