INSURANCE ELIGIBILITY FORM

Fax this form & required documentation to 720-358-5139 OR email to insurance@tbh.com	***REQUIRED DOCUMENTATION TO INCLUDE:*** • A front and back copy of your insurance card(s) • A copy of diagnosis from a qualifying medical provider

If you are a *NEW CLIENT,* how did you hear about TBH? ______________________

If you are an *EXISTING CLIENT* , do you have a new insurance plan or policy? ☐ Yes ☐ No

CLIENT INFORMATION

Client Name ______________________ ☐ Male ☐ Female

Date of Birth ______________________ Home Phone ______________________

Address ______________________ Cell Phone ______________________

City/State/Zip ______________________ Email ______________________

Autism Diagnosis ☐ Yes ☐ No If no, specify which diagnosis ______________________

Therapy Needed ☐ ABA ☐ Speech* ****Speech only at the Fort Collins, CO location***

Is client receiving an ABA assessment from another provider? ☐ Yes ☐ No ABA services? ☐ Yes ☐ No

INSURANCE INFORMATION

	PRIMARY INSURANCE	**SECONDARY INSURANCE**
Employer Name		
Subscriber Name		
Relationship to client		
Subscriber Birthdate		
Home Address (if different from client)		
Insurance Co Name		
Insurance Co Phone		
Group/Plan #		
Member ID#		

For Military Personnel Only

DOD# ______________________ Active Duty ☐ Yes ☐ No

Social Security # ______________________

VERBAL CONSENT

I understand that as part of my dependent's healthcare, Trumpet Behavioral Health (TBH) may use my dependant's health records describing health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment for the purpose of researching my dependant's health insurance benefit information. I give TBH permission to discuss my dependant's personal health information with my insurance carrier(s). All information listed herein is complete and accurate to my knowledge. The insurance carrier(s) listed is/are the only applicable insurance funding for my dependant as of the date signed below.

Signature of Policy Holder ______________________ Date ______________

☐ I attest that the policy holder verbally consented to the above statement. Completed by ______________________

RESPONSIBLE PARENT/GUARDIAN

TBH provides insurance eligibility and financial services. Please list the primary contact for financial information.

Name of Parent/Guardian ______________________

Best contact email or phone ______________________