# VERIFY YOUR INSURANCE

If you have health insurance, please enter your information below to allow us to do a free verification of benefits to determine your coverage for our services. ALL INFORMATION YOU SUBMIT IS CONFIDENTIAL:

* First Last Name (optional)
* Name of Person Seeking Treatment (if Different than Above) (required)
* Name of Insured (If Different Than Above) (optional)
* Date of Birth of Person Seeking Treatment\* (required)
  + MM
  + DD
  + YYYY
* Email (required)
* Phone (required)
* Address, City, State, Zipcode (optional)
* Insurance Carrier required
* Type of Plan (optional)
  + PPO
  + HMO
  + Medicaid
* Group number: (required)
* Policy number: (required)
* Phone Number on Back of Card, Marked "Provider" (required)
* AND Phone number on back of Card marked "Mental Health" “Substance Abuse” or “Behavioral Health” (required)
* If this is through an employer, please indicate the name of the employer. (optional)
* Comments / Brief Description of the Issue (optional)