



De Sellers, LPC

901 East 12th Street
Austin, TX 78702
ofc 512.499.8994
fax 512.322.9908

INSURANCE VERIFICATION FORM

Name _____ Date _____

Mailing Address _____

Home Phone _____ Work _____ Cell _____

Date of Birth _____ SS# _____

First Appointment _____

Insurance Information:

Name of Insurance: _____

Insurance Phone (from back of card) _____

ID# _____ Group # _____

Policy Holder Information , if different from client

Name _____ Date of Birth _____

SS# _____

Client Relationship to Policy Holder _____

Release of Information and Assignment of Benefits

I authorize the release of any medical or other information necessary to process this claim. I also request payment of medical benefits to the undersigned supplier who accepts assignment for services described below.

Signature Date