Patient Eligibility

In order to determine benefits, please complete the information below and attach a copy of your insurance card front and back.

Client Information		***FOR OFFICE USE***	
Client Name (Last, First)		**Individual BCBA**	
Date of Birth		**Initial Assessment Hours to Request**	
Sex/Gender		**Initial Assessment Projected Start Date**	
Diagnostic Code / Description		**Projected Treatment Hrs to Request**	
Home Address (No., Street)			
City			
State			
Zip code			
Phone Number			
Primary Insurance Information		***Please provide copy of Insurance card- FRONT & BACK***	
Primary Insurance Company			
Insured's I.D. Number			
Name of Primary Subscriber			
Date of Birth of subscriber			
Relation to client			
Subscriber Employer Name (if known)			
Parent contact email address			
Additional Information			