GERSH ABA SERVICES
Initial Insurance Verification

****Must send Copy or Photo Front & Back of Insurance Card(s)**

Child's Name _____ Date of Birth: _____ Gender: _____

Does child have an Autism Spectrum Disorder Diagnosis? (Y/N) _____ (Please submit copy of diagnostic report)

Date of Diagnostic Evaluation: _____ Name of Diagnosing Doctor: _____

Any other Diagnoses? If so, please list: _____

Preferred Schedule for my child (Circle): Full Day Half Day After School Weekends

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PRIMARY INSURANCE Name of Subscriber: _____

Insurance Company: _____ Policy/Member ID: _____

Relation to Child: _____ Subscriber Date of Birth: _____

Address: _____

SECONDARY INSURANCE Name of Subscriber: _____ Medicaid Policy? (Y/N): _____

Insurance Company: _____ Policy/Member ID: _____

Relation to Child: _____ Subscriber Date of Birth: _____

Address (If different from above): _____

Name of Primary Contact Parent/Gradian: _____

Home Phone: _____ Cell Phone: _____

Email: _____

Preferred method of communication during business hours: _____

How did you hear about us? _____

I authorize the release of insurance and benefits information to Gersh ABA Services. I understand that a quote of benefits and/or authorization does not guarantee payment from my insurance company. Payment of benefits is subject to all terms, conditions, limitations, and exclusions of the member's contract at time of service. I understand that I am responsible for alerting Gersh ABA Services of any changes in my insurance and financially responsible for any balance.

_____

Signature/Release Date