Greg Thigpen, PsyD
Clinical Psychologist
License Psy19198

Insurance Benefits Verification

Date: _____

Client's Name: _____ Date of Birth:_____

Relationship to Insured: _____

Insured/Subscriber Name: _____Date of Birth :_____

Address:_____

City: _____ State: _____ Zip: _____

Cell Phone: (____)_____ Home Phone: (____)_____ Work Phone: (____)_____

Employer:_____

Insured/Subscriber ID/SUB #: _____

Group #:_____

Insurance Name: _____

Phone:(_____)_____

Address:_____

City:_____State:_____ Zip:_____

Authorization/Kit #:_____ Authorization Date: _____

# of Sessions per calendar year: _____ Copay $: _____

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