

# INSURANCE BENEFITS VERIFICATION

Cornerstone Recovery Inc.

6221 Main St., Houston, TX 77030

(713) 303-9109, fax: (713) 874-1410

[phyllis@cornerstonerecovery.org](mailto:phyllis@cornerstonerecovery.org)

*Complete all information and include a copy of the front & back of your Insurance card*

## Client

Name: \_\_\_\_\_ D.O.B. \_\_\_\_\_

Social Security #: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Please check the appropriate space – Out Patient Group \_\_\_\_\_ Individual Sessions \_\_\_\_\_

## Insurance Carrier

Name of Company: \_\_\_\_\_

Contact number for mental health/ substance abuse: \_\_\_\_\_

Policy Holder \_\_\_\_\_ Policy Holder DOB \_\_\_\_\_

Policy Holder address (if different): \_\_\_\_\_

City, State, Zip (if different): \_\_\_\_\_

Policy holder SSN: \_\_\_\_\_

Employer: \_\_\_\_\_

Group #: \_\_\_\_\_ Member I.D #: \_\_\_\_\_

## Responsible Party for Co-payment

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Email address: \_\_\_\_\_

(h) \_\_\_\_\_ (w) \_\_\_\_\_ (c) \_\_\_\_\_

# INSURANCE BENEFITS VERIFICATION

Cornerstone Recovery Inc

6621 Main St., Houston, TX 77030

(713) 303-9109, fax: (713) 874-1410

[phyllis@cornerstonerecovery.org](mailto:phyllis@cornerstonerecovery.org)

Office use only

---

*Benefits*

Deductible:

Co-Pay:

Co-Insurance:

Maximum Sessions Per Cal Year:

Claims Address:

Other Info:

Client Status:

Date Verified:

Verified By: