PEDIATRIC SPEECH THERAPY

Insurance Information Form

Thank you for choosing Voz Speech Therapy as your speech therapy provider!

Speech, language, and orofacial myofunctional therapy sessions are not always a covered benefit with your insurance company and may not be considered medically necessary. A quote of benefits from your insurance company is not a guarantee of payment and should therapy sessions be denied, the patient/family is ultimately responsible for payment. You are also responsible for payment of any deductible, coinsurance, or copayment as applied by your insurance. If your account is ever sent to outside collections for non-payment, you will also be financially responsible for any collection fees.

By submitting this form, you are providing consent to Voz Speech Therapy's medical billing team to contact your insurance company on your behalf for information about coverage of the service(s) provided. We thank you for the opportunity to help you and your family!

Appointment Date: _____

Patient Name: _____

Patient DOB: _____

Name of Parent/Legal Guardian/Subscriber: _____

Email of Parent/Legal Guardian/Subscriber: _____

Phone Number of Parent/Legal Guardian/Subscriber: _____

Address of Parent/Legal Guardian/Subscriber: _____

PLEASE SEND A COPY (FRONT AND BACK) OF ALL INSURANCE CARDS TO INFO@VOZSPEECHTHERAPY.COM ALONG WITH THIS FORM. IF INSURANCE INFORMATION AND A COPY OF THE CARDS ARE NOT RECEIVED AT LEAST 24 HOURS BEFORE YOUR SCHEDULED APPOINTMENT, THE SESSION WILL AUTOMATICALLY BE RESCHEDULED.

Primary Insurance Name: _____

Employer and Group Name: _____

Insurance Identification Number (please include all letters and hyphens): _____

Insurance Group Number: _____

Insurance Provider Phone Number: _____

Secondary Insurance Name: _____

Secondary Employer and Group Name: _____

Secondary Insurance Identification Number (please include all letters and hyphens): _____

Secondary Insurance Group Number: _____

Referring Physician Name and Number (if applicable): _____

Primary Care Physician Name and Number: _____

What is the best time and method for us to contact you regarding scheduling and/or your benefits? Please include a preferred phone number or email, and any times/dates that work best for your schedule: _____

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By signing this form, you are providing consent and acknowledging that the information provided is correct to the best of my knowledge and is legally binding.

_____ _____

Signature Date