



GREG THIGPEN, PSYD

LICENSED 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 \$: _____