Miami Valley Tutoring Services

Insurance Verification Form

Today's Date:	**Primary Care Physician:**

CLIENT INFORMATION

Last Name:	First Name:	Middle Name:	Date of birth:	Age:	Sex:
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Street Address:	City:	Zip code:

INSURANCE INFORMATION

Insurance Provider:	Subscriber Name:	Subscriber DOB:	Home Phone Number:
Client's Relationship to Subscriber:	Secondary Insurance (if applicable):	Subscriber Employer:	Subscriber Email:

Services Requested:

_____ ABA Therapy

_____ Speech Language Pathology

****Please attach a copy of the front and back of your insurance card**

*****Allow a week for verification response**

The above information is true to the best of my knowledge. I authorize Miami Valley Tutoring Services or insurance company to release any information required to process my claims.

Patient/Guardian signature

Date

Submit verification form and insurance card to Erika Russ at erikamvts@gmail.com or 919 S. Central Ave., Fairborn, OH 45324