INSURANCE ELIGIBILITY FORM

Fax this document and required documentation to 626-355-5173 or email to info@totalprograms.org	*Required Document* *-a copy of your insurance card front/ back* *-a copy of the diagnosis from qualifying provider*

If you are a new client, how did you hear about TOTAL Programs _____
If you are an existing client, do you have a new insurance provider? Y N N/A

CLIENT INFORMATION

Client name	*Date of birth*
Address	*City State Zip*
Home phone	*Cell phone*
Email	
Parent(s) name	

Autism diagnosis? Y N Year of diagnosis: _____
If no, specify details _____
Is client receiving an ABA assessment from another provider? Y N
Is client currently receiving ABA services from another provider? Y N
If so, which provider and for how long: _____

INSURANCE INFORMATION

	Primary Insurance	Secondary Insurance
Employer Name		
Policy Holder Name Relationship to Client		
Holder Date of Birth		
City/State/Zip if different than client		
Insurance Name and Phone		
Group/Plan #		
Member ID #		

CONSENT- I understand that as part of my dependent's health care, TOTAL Programs may use my health records describing by health history, symptoms, examination and test results, diagnosis, treatment, and any plans for future discuss my personal health information with my insurance carriers (s).
Signature of Policyholder: _____

RESPONSIBLE PARENT/GUARDIAN- TOTAL Programs is involved in insurance eligibility and financial services. Please list the primary contact person in the home for financial information.
Name (s) of Parent/Guardian _____
Best contact phone or email _____