BrainHealth Solutions

Insurance Eligibility & Service Referral Form

Patient Name_____Date of Birth_____Phone: _____

Home Address_____

Email Address _____

Insurance Company _____

Insurance Phone: _____

Member Insurance ID No._____Group ID No._____

Policy Holder Name_____Date of Birth _____

Policy Holder Relationship to Patient_____

Please CHECK all that apply and LIST details below:

☐ ***Psychiatric evaluation***

☐ ***Medication Management***

☐ ***Transcranial Magnetic Stimulation (TMS)***

Reason for treatment: Check one: New patient ☐ Returning patient ☐

_____

Signature below authorizes BrainHealth Solutions to disclosure information to your insurance company to check benefits and if benefits are used, to bill the insurance company.

_____Date_____

Signature

Send this form and a copy of the front/back of the insurance card to Bota4TMS@gmail.com

_____

Print Name

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