

**THIS INFORMATION IS CONFIDENTIAL
APEX MANAGEMENT & BILLING SERVICES, INC.**

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APPOINTMENT SCHEDULING FORM FOR _ELIZABETH DETWEILER, LCSW

Date: _____

Patient's Name: _____ **Age:** ___ **Date of Birth** _____

Address: _____ **Phone number to be reached:** _____

Email Address: _____

Scheduled Date: _____ **Time:** _____

INSURANCE INFORMATION

Primary:

Insurance Name: _____ **Group #:** _____

Insured's Name: _____ **Policy #/ SS#:** _____

Insured's Date of Birth: _____

Secondary:

Insurance Name: _____ **Group #:** _____

Insured's Name: _____ **Policy #/ SS#:** _____

Insured's Date of Birth: _____

OFFICE USE ONLY

Effective Date of Coverage: _____ **Patient's co-payment:** _____

Is there a deductible?: ___ **If yes, how much?:** _____ **How much has been met?:** _____

Is pre-authorization required?: _____ **If yes, authorization number:** _____

Are there maximum visits?: _____ **How many have been used?:** _____

90847 approved?: _____ **90808 approved?** _____

Notes: