If you would like us to assess your insurance benefits, please fill out this secure Benefit Verification Form. We will only run it with your permission after an intial phone call with our admissions director.

Fire Mountain Residential Treatment Center, Inc.	**Tax ID# 45-3072422**	**NPI# 181 124 1151**	**5532 US Hwy. 36**
Date Recvd:	**Time:**	**Staff:**	**Estes Park, CO. 80517**

Client Name:

DOB:	**Sex:**

Client SS#:	**Client Ph:**	**Client PhW:**

Client Address:

Insured:	**Ins. DOB:**	**Ins. SS#:**	**Insured Relation:**

Employer:	**Ins. Company:**	**Ins. Co. #:**

ID#:	Group#:	Type of Plan:

*************STOP *************DO NOT FILL OUT BELOW THIS LINE**********************************

Pre Cert Ph#:	Current Condition/DOC:	Prior Treatment?	Explain:LOC and where?
Penalty/No Pre-cert			
Claims address: payer ID:			
Claims Phone #			

Is this plan a PPO In Network?	PPO Out of Network?	Commercial/Indemnity?

Level of Care:	In Network %	Out of Network%	Deductible/ Copay	Verify Maximum Etc.	Days Used	Rate Per Day
Lab Tests						
Detox (hosp.?)						
Residential						
Partial						
Intensive OP						
Outpatient fc/pro						

Annual Max-
Lifetime Max-

Admit Copay for Detox	Admit Copay for RTC	Admit Copay for PHP	Admit Copay for IOP	Admit Copay for OP

IN Network Ins. Eff. Date:	Deductible? Ind. $ Fam $	Has Ded been Met? Ind. Fam	Amt: Remaining: Ind. $ Fam $
MAX OOP: Ind. $ Fam $	Met? Ind. Fam	Amt Remaining: Ind. $ Fam $	Must Client meet Family Ded ? OOP?

Out Of Network	Deductible? Ind. $ Fam $	Has Ded been Met? Ind. Fam	Amt: Remaining: Ind. $ Fam $
MAX OOP: Ind. $ Fam $	Met? Ind. Fam	Amt Remaining: Ind. $ Fam $	Must Client meet Family Ded ? OOP?

Is the policy work, ind, ACA?	Primary? Secondary?
Are the in/out net ded/OOP combined?	MH/SA benefits carved out?
Is it a calendar year?	If no, note renewal date:
Leave the State for TX?	Residential Centers Excluded?
Pre-Cert Reqd?	Pre Existing Conditions/Exclusions:?
Deductible applied to Max OOP?	Licensed Free Standing okay?
MH/SA Combined?	Allowed Amount?
Claims paid to Assigned?	Medicare Schedule?
JCAHO/CARF?	MNNRP?
Carry Over?	National Advantage Plan?
Cobra? If Yes on Cobra ID# :	Option 2 Plan?
Is Skype/Telehealth covered?	Timely Filing?
OP auth/Rev code?	AOB honored, send to clm address?

VOB rep:	Date	Ins. Rep. Name	Call Reference Number
Doris	05/14/2018		
Jan	05/14/2018		

Client Name: Amy Davis