DAWNN R. MCWATTERS, Psy.D.
Licensed Psychologist (Oregon and Washington)

Insurance Verification Form

Please call your insurance plan or verify benefits online, prior to our first appointment. Complete all applicable portions of this form, if possible.

Name of Insured _____ (circle one) Self Spouse Parent Other

Insurance Company _____Phone # _____

Insurance Address _____

Group # _____ Identification # _____

Effective date _____ D.O.B. of insured (if not client) _____

To the best of your understanding, am I "in-network" □ or "out-of-network" □ (check one)?

Please complete the following information based upon my status with your insurance plan:

Deductible Amount _____ Met? □ No □ Yes Copay per Visit _____

Preauthorization required? □ No □ Yes Do sessions limits exist? □ No □ Yes

Do you have secondary insurance coverage? □ No □ Yes (If so, complete the following)
Name of Insured _____ (circle one) Self Spouse Parent Other

Insurance Company _____ Phone # _____

Insurance Address _____

Group # _____ Identification # _____

Effective date _____ D.O.B. of insured (if not client) _____

To the best of your understanding, am I "in-network" □ or "out-of-network" □ (check one) with your secondary plan?

Deductible Amount _____ Met? □ No □ Yes Copay per Visit _____

Preauthorization required? □ No □ Yes Do sessions limits exist? □ No □ Yes