Welcome to UCP of Central Arizona Therapy

Consent to Use Insurance

Child's Name: _____ Date of Birth: _____

Division of Developmental Disabilities (DDD) and Arizona Long Term Care (ALTCS)

Do you have a DDD Service/Support Coordinator? __Yes __No ALTCS Eligible? __Yes __No
If Yes, Name of Service/Support Coordinator: _____
Phone Number: _____ Email:_____@azdes.gov

Private Pay Options

___ Check here if you elect to pay out-of-pocket for Therapies.
Payment is due on the date of service.
We accept Cash, Check, Debit, MasterCard, VISA, American Express, and Discover.
Private Pay cost is $250 for therapy evaluations and $100 per one-hour therapy session.
Please contact us for private pay packages and/or scholarship opportunities.

Primary Insurance Information:

Insurance Carrier: _____Health Plan, if applicable: _____
Insurance ID#:_____ Policy Group #:_____
Name of Policyholder: _____Policy Holder's Date of Birth: _____
Relationship to Child: _____ Policyholder's Employer: __ _____
Claims Address: _____ Phone #: _____

Secondary Insurance Information:

Insurance Carrier: _____Health Plan, if applicable: _____
Insurance ID#:_____ Policy Group #:_____
Name of Policyholder: _____ Policy Holder's Date of Birth: _____
Relationship to Child: _____ Policyholder's Employer: __ _____
Claims Address: _____ Phone #: _____

Verification of Benefits, Consent to Use Insurance, and Release of Information

I hereby certify that the information provided is true and correct.
I authorize UCP of Central Arizona (UCP) to use the above information to verify my insurance benefits to determine coverage of services. I understand that my insurance benefits are determined by the contract I hold with my insurance company and the request for prior authorization does not guarantee payment for therapy.
I understand that I am responsible for all fees and will be charged for any and all treatment not paid by the insurance carrier, for families that do not hold a DDD or AZEIP contract. I understand that co-pays/deductibles/co-insurance must be paid on the date of service (private insurance/self-pay only).
I give consent for UCP of Central Arizona to bill my insurance for agreed upon therapy services.
I understand this consent allows UCP of Central Arizona to release and share information with my insurance company to assist in obtaining authorizations and payment of claims.

_____ _____
Signature of Responsible Party Date

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