

INSURANCE COVERAGE INQUIRY

Print and use the following form when calling your insurance company to inquire about **Outpatient Mental Health** benefits. By speaking directly to your insurer, you are fully informed what your out-of-pocket expenses will be. Have your insurance card available when you call and bring the completed form to your first visit.

Insurance Company Name _____
Company Telephone _____
Service Representative Name and/ Ext. _____
Date of Telephone Inquiry _____

1. My selected provider is _____
Is she/he currently a network provider under my plan?

2. **IF YES, In Network Benefits applies.**

Is Pre-Authorization required? Yes ___ No ___

How do I request authorization? _____

Is there a **DEDUCTIBLE**? If yes, How much is it? _____

How much of it has been met? _____

When does the deductible come due again? _____

How **many visits** are approved? _____

Which CPT codes are allowed?

90801 (Initial Evaluation)= Yes ___ No ___

90806 (Individual Therapy)= Yes ___ No ___

90847 (Family or Couples Therapy)= Yes ___ No ___

(other) _____ =Yes ___ No ___

What is the **COPAY** per session? _____

Is there an **Authorization Reference Number**? _____

3. If NO, Then he/she is an Out of Network provider. You may still have benefits, but you will have to pay the full session fee at each visit. Your therapist will give you the appropriate form for you to file with your insurance. Your insurance company will then reimburse you an amount determined by the contractual provisions and limitations of your plan.

4. How many **Sessions** for Outpatient Mental Health services are permitted per year? Or, is there a maximum amount paid for these services per year?

Maximum # of sessions per year =

Maximum \$ paid for sessions per year =

Maximum lifetime benefits for Outpatient Mental Health=

5. Are there **EXCLUSIONS** to my coverage for specific types of treatments or conditions?

Is **Family Therapy** covered?

Is **Couples Therapy** covered?

Are there any specific conditions that are **NOT** covered (e.g., Sleep Disorders, Gender Identity Disorder)

Are **Pre-Existing conditions** covered?

6. What is the **Claims mailing address** and **Claims telephone number**?

CLAIMS ADDRESS=

CLAIMS TELEPHONE=