

INSURANCE BENEFITS INFORMATION FORM

To verify your mental/behavioral health coverage, please call the customer service number on your insurance card and complete the following information:

Client's Name: _____

Client's Date of Birth: _____ Client's Soc. Sec. #: _____

Policy Holder's Name (if different from client): _____

Policy Holder's Date of Birth: _____ Policy Holder's Soc. Sec. #: _____

Name of Primary Insurance - Behavioral Health Insurance Plan: _____

***Note: this may be different from your physical health insurance plan**

Member ID#: _____ Group #: _____

Do I have mental/behavioral health coverage? yes no (If no, STOP....If yes, continue)

Name of therapist: _____

Is this therapist in network? yes no (If YES, complete In-Network Coverage below)

If NO, do I have Out of Network coverage? yes no (If YES, complete Out-of-Network Coverage below)

In-Network Coverage:

What is my copay amount? \$ _____

Do I have a deductible? yes no If YES, what is my deductible amount? \$ _____

Out-of-Network Coverage:

How much will I be reimbursed if I see an Out-of-Network therapist? _____

Do I have a deductible? yes no If YES, what is my deductible amount? \$ _____

Services Covered:

Are the following services covered under my policy?

Individual Therapy (CPT Code – 90806) yes no

Couples/Family Therapy (CPT Code – 90847) yes no

Group Therapy (CPT Code – 90853) yes no

Psychological Testing (CPT Code – 96101) yes no

Authorization

Is an authorization required? yes no

If YES, what is my authorization number? _____ # of sessions authorized: _____