INSURANCE VERIFICATION WORKSHEET

The provider has agreed to discount fees with a number of insurance companies in order to serve as a network or "preferred" provider. The provider may or may not be a preferred provider on your plan. Benefits vary depending on plans. It is important that you know your plan benefits. Please print and complete this worksheet by calling your insurance company to verify your mental health plan benefits. Please bring your insurance card and the completed form to your first session. Thank you.

Insurance Company:		Insurance Company Phone:			
Name of Patient (person being seen):				Date of Birth:	
ID#		Group #			
Name of Insured (policy holder):				Date of Birth:	
Phone/e-mail of Insured:					
Address of Insured:					
	City	State		Zip Code	
Patient relationship to Insured (circle):	SPOUSE	PARENT	CHILD	OTHER	

PLEASE OBTAIN ANSWERS TO THE FOLLOWING QUESTIONS:

Is my mental health insurance a PPO, HMO, EPO or other? (PPO) (HMO) (EPO) (OTHER)

Is preauthorization required for mental health services? (Y) (N) If yes, authorization#: _____

Is my insurance based on a calendar year? (Y) (N) If no, what is my insurance year? _____

Is my provider considered "in network" or "out of network"? (IN) (OUT)

If "out of network", do I have "out of network" insurance benefits? (Y) (N)

What is my deductible for outpatient mental health services?

How much of my deductible have I met this insurance year?

Do I have a co-pay per visit? (Y) (N) If yes, how much do I pay my provider at each session? _____

Is there a yearly dollar limit? (Y) (N) If yes, how much have I used this year? _____

Is there a yearly session limit? (Y) (N) If yes, how many sessions have I used this year? _____

Is there a limit to the number of sessions I may receive each week? (Y) (N)

Are there any diagnostic codes my plan does not cover? _____

To which company/address are claims to be sent?

_____

_____

_____