Client's Name: _____ DOB: ____-____-_____

Policy Holder's Name (if not client): _____ DOB: ____-____-_____

Primary Insurance /Behavioral Health Insurance Plan:

_____

Note: This may be different from your medical health insurance plan

Member ID #: _____ Group #: _____

Questions for Your Insurance Provider

1) "Do I have mental/behavioral health coverage?" □ YES □ NO

(If YES, continue. If NO, there is no need to proceed, other payment arrangements must be made.

Please contact the therapist to discuss payment options.)

2) "Is my therapist _____in network?" □ YES □ NO

(If YES, go to In-Network Coverage, If NO go to question 3)

3) "Do I have Out-of-Network benefits?" □ YES □ NO

(If Yes, go to Out-of-Network benefits. If NO, there is no need to proceed, other payment arrangements

must be made. Please contact the therapist with whom you want to work with to discuss payment options.)

In-Network Benefits

4) "What is my co-pay amount?" $_____

5) "Do I have a deductible?" □ YES □ NO $_____

6) If YES, "What is my deductible?" $_____

(Now proceed to Services Covered)

Out-of-Network Benefits

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

8) "Do I have an Out-of-Network deductible?" □ YES □ NO

If YES, "What is my out-of-network deductible?" $_____

Services Covered

9) “Please verify that the following services are covered under my policy?”

Individual Therapy (CPT Code 90834) □ YES □ NO

Individual/Couples/Family Therapy (CPT Code 90837) □ YES □ NO

Group Therapy (CPT Code 90853) □ YES □ NO

Tele-health □ YES □ NO

Services Authorized

10) “Do I need an authorization to receive any of these services?” □ YES □ NO

If YES, “What is my authorization number?” _____ and

11) “How many sessions are authorized?” _____.