



### Insurance Verification Sheet

Please call your insurance company prior to your initial appointment. On the back of your card (typically) locate the telephone number provided for Mental Health/Substance Abuse and/or Behavioral Health.

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Insured's ID: \_\_\_\_\_ Group ID: \_\_\_\_\_

Effective Date: \_\_\_\_\_

Insurance Name: \_\_\_\_\_

Telephone #: \_\_\_\_\_ for benefits

Please make sure to request outpatient mental health benefits when calling. Ask and complete the following:

Does your plan cover counseling by a Licensed Professional Counselor? \_\_\_\_\_  
Is the provider you are scheduled to see (e.g., Bonnie Craven or Andrea Liverman) an in-network provider? \_\_\_\_\_ If not, ask if your plan pays for out-of-network benefits: \_\_\_\_\_

Is there a deductible? \_\_\_\_\_ If so, have you met the deductible? \_\_\_\_\_  
What percentage of the deductible has been met? \_\_\_\_\_

What is your co-pay or percentage you are expected to pay? \_\_\_\_\_

Does your plan cover family therapy (CPT Codes 90847 & 90846)? \_\_\_\_\_

Is there a limit on visits per year? If so, how many visits per year are you issued \_\_\_\_\_  
How many visits have you used? \_\_\_\_\_

Do the service limits run per traditional calendar year? \_\_\_\_\_ If not, how does the year run? \_\_\_\_\_

Do outpatient mental health services require authorization? \_\_\_\_\_ Is a treatment plan required? \_\_\_\_\_

If authorization is required and you are planning on family therapy, or if patient is a minor, please inform the insurance company that you are requesting family and individual visits.

If any services you are requesting, require authorization, please obtain the authorization number and list here: Auth Number. \_\_\_\_\_ Effective dates: \_\_\_\_\_  
from \_\_\_\_\_ to \_\_\_\_\_ Auth good for how many sessions \_\_\_\_\_



Are there any mental health diagnoses excluded under your mental health plan, related to your presenting concerns (e.g., depression, ADHD, Autism Spectrum Disorder, etc?)

Inquire regarding a submittal address for mental health services (this is not always the same as what's shown on your card)

\_\_\_\_\_

Name of representative you spoke with: \_\_\_\_\_ Date of call: \_\_\_\_\_

Signed: \_\_\_\_\_

Date: \_\_\_\_\_