Insurance Verification Worksheet

Client Name: _____ **Parent Name:** (if child is client) _____

Insurance Information: *Please phone your Insurance Company and fill out this form the best you can.* ***This is Very helpful information if you are unfamiliar with your coverage.***

Name of Insurance: _____ **Phone:** _____
Claims Address: _____
Insured's Name: _____ **ID #:** _____
Plan/Grp #: _____

When you call be sure to write down the name of the person that you talk to for later reference.

HMO Contact Person: _____ **Date, Time of call:** _____

Say, "I'm calling to clarify my benefits and coverage for out-patient mental health." (They will ask for your member ID #) Ask enough questions to complete all of the information. Incomplete information will require another phone call.

Is my therapist, _____ , on the Participating Provider List? (Name your therapist; you may find that information on your insurance's website, but do remember that the website might not be up to date).

Peggy Casebeer, MN, PMHNP	Psychiatric Mental Health Nurse Practitioner
Bob Davidson, M.Div.,M.Ed, LMFT	Licensed Marriage and Family Therapist
Wendy Galambos, M.A, LPC	Licensed Professional Counselor
Joellen Lee, LCSW	Licensed Clinical Social Worker

If your therapist of choice is NOT on their panel, then ask these questions:

"Does my policy allow me to choose my own therapist?"
"Can I go outside of panel or the provider list?" (If so, "Is my coverage different, and what difference?")

Then ask: "What is my:

Copay: _____ % **or** $ _____**/session. Whichever is less. Effective Date of Policy:**_____

Deductible? No Yes **Amount of Deductible** $ _____/ **family or individual?**

Deductible Per Calendar Year? Yes No **Month Deductible Begins** _____

Has any Deductible been met for this year? No Yes **If yes, how much?**_____

Is Pre-authorization needed? No Yes **Any benefits used to date?** Yes No

 # Visits allowed per calendar year _____ **# Visits allowed per 24 Consecutive months** _____
Beginning:_____