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INSURANCE VERIFICATION FOR MENTAL HEALTH BENEFITS

You can use this form when you call your insurance company to get all your questions answered. You will find the information you need on your card.

Date of call_____________ Patient name________________

Subscriber name (if different)__________________ Subscriber date of birth_______

Subscriber ID#_______________________ Group #______________

Insurance company name_______________ Phone number____________________

Effective coverage dates______________**Mental health benefits?** Yes No

Are there limits to these m.h. benefits? Y/N If yes, # of visits______

Have any benefits been used this year? Y/N If yes, # of visits used______

Does this plan have a **deductible**? Y/N If yes, does it apply to m.h. benefits? Y/N

How much is this deductible?______

How much has been met this year?_______

Is there a **co-pay or co-insurance**?

If co-pay, how much is it per session?_________

If co-insurance, what percentage of allowable amount is patient responsibility? _____

My ultimate responsibility will be (deductible, co-pay + co-ins):_________________

Do I need any kind of **referral or authorization** before beginning services? Y/N

If yes, what do I need to do?

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