How to Obtain Information for In or Out of Network Benefits & Claims

I look forward to working with you, but I recommend that you call your managed care (health insurance) company to determine your benefits prior to beginning therapy.

Payment by cash, check or charge card is due at time of service, but we will submit your claims on your behalf to get you reimbursed directly from your insurance company. **This reimbursement will be sent directly to you if your therapist is out of network and your plan has out of network benefits.**

Please call your insurance company to obtain the following specific plan details. Patient Name _____ DOB _____/_____/_____ Insurance Co._____ Type of plan: HMO POS PPO EPO or Other Policy ID#_____ Group ID#_____ Policyholder Name_____ Policyholder DOB____/____/_____ Policyholder relationship to patient _____ policy holders SS# _____

Questions to ask your insurance company (please fill in the answers): Effective Date of policy _____

1. Is my therapist in-network or out of network _____
    a. * John-Mike Nelson, LPC- NPI # 1700159563
    b. * Joseph Wall, LPC, LMFT – NPI #1992326458
    C. *Kate Lewis, LCSW - NPI #1457385486
2. What is my mental health outpatient co- pay? $ _____ or co-insurance? _____
3. Do you I have a deductible for mental health benefits? Yes / No
    a. . How much is the deductible$_____
    b. . How much have I met? _____
4. How much will I get reimbursed if I pay for the following services:
    a. Initial Intake (code 90791): $200 _____
    b. Session (code 90837): $175 _____

5. Are there a maximum number of yearly visits allowed? Yes / No; if yes, how many _____ 6. Does your plan have a lifetime maximum mental health benefit? Yes / No Amount _____ 7. Does your plan require pre-authorization for mental health benefits? Yes / No

8. If YES, please provide your insurance company with your therapist name.

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9. Authorization #: _____ Start Date: _____ End Date: _____

Authorization details & coverage(not necessary, but if it sounds like it might apply to you, then continue):

- 90791 (Initial Evaluation) Yes / No
- 90837 (Individual therapy 60 minutes) Yes / No # of visits allowed: ____ • 90846 (Family therapy without patient present) Yes / No # of visits allowed: ___ • 90847 (Family therapy with patient present) Yes / No # of visits allowed: ___ • 90853