INSURANCE BENEFITS VERIFICATION FORM

Thank you for choosing Counseling Connections, LLC. You are responsible for contacting your insurance company to avoid unexpected bills. Counseling Connections, LLC may also call to verify coverage as a courtesy, but you are ultimately responsible for any balance not covered.

Client Name: _____ DOB: _____
Policy Holder's Name: _____ DOB: _____
Address _____ Phone: _____

Insurance: _____ Member ID#: _____
Behavioral Health Phone: _____ Dependent ID: _____
Customer Service Phone: _____ Group #: _____

*Call either the behavioral health phone number or customer service, ask the representative SAY: I NEED TO VERIFY MY OUTPATIENT MENTAL HEALTH COVERAGE.

Questions for your Insurance Provider Representative:

1) Do I have mental/behavioral health coverage? ☐ Yes ☐ No
   (*If YES, continue. If NO, there is no need to continue. Contact us to discuss payment options)*
2) Do I need a referral from my doctor? ☐ Yes ☐ No
3) Is my preferred therapist, [Marcia Filipiak, LPCC] NPI # 1164808606, in network? ☐ Yes ☐ No
   If not, is Counseling Connections NPI # 1114589322, in network? ☐ Yes ☐ No
   (*If YES, go to In-Network Coverage. If NO, go to Question 4.)*
4) Do I have Out of Network Benefits? ☐Yes ☐No
   (*If YES, go to Out-of-Network Benefits, below. If NO, contact us to discuss payment options)*

In-Network Coverage

5) Do I have a co-pay? How much? $_____
6) Do I have co-insurance? How much? %___
7) Do I have a deductible? ☐ Yes ☐ No
   7a) Does it apply to mental health? ☐ Yes ☐No
   7b) What is my deductible? $_____
   7c) What date does it restart? _____
   How much remains on my deductible? _____
8) How many visits do I get per year? _____

Out-of-Network Benefits

4) How much will I be reimbursed if I see an Out-of-Network therapist? _____
5) Do I have an Out-of-Network deductible? ☐ Yes ☐ No If yes, how much? _____
   5b) How much remains $ _____
6) Do I have Out-of-Network co-insurance? ☐ Yes ☐ No If yes, how much? %_____

Services Authorized

9) Do I need authorization to receive any of these services? ☐ Yes ☐ No
   If YES, What is my authorization number? _____
10) How many sessions are authorized? _____

Services Covered

11) Can you please verify that individual therapy is covered under my policy:
    CPT codes: 90837 ☐Yes ☐No 90834 ☐Yes ☐No 90832 ☐Yes ☐No 90791 ☐Yes ☐No
12) Can you please verify that telehealth individual therapy is covered under my policy?
    90837-GT ☐Yes ☐No 90834-GT ☐Yes ☐No 90832-GT ☐Yes ☐No 90791-GT ☐Yes ☐No

Where do I send claims: _____
_____