CHECKING COVERAGE: 13 ESSENTIAL QUESTIONS

BEFORE CALLING INSURANCE: INFO TO GET FROM THE CLIENT / CARD

Client Name: _____ **Client Birthdate:** _____ /_____ /_____
I.D. # :_____ **Group #:** _____
Insured Name (if other than client): _____ **Relationship to Client:** _____
Insured's Birthdate:_____ /_____ /_____ **Insured's Employer**_____
Insurance Phone Number (*The card may say "MH/SA Benefits," "Eligibility and Benefits," For Pre-Authorization," "Customer Service"):* _____

THE CALL: WHAT TO ASK THE INSURANCE COMPANY

CALL DATE: _____ /_____ /_____ **REPRESENTATIVE NAME**_____

Request outpatient mental health benefits." Tell them if you're a network provider.

1. Copayment (flat fee) **or Coinsurance** (percent)	
2. Deductible (if applicable)	
3. Sessions Allowed per Year	
4. Are Benefits In Effect? When Do They Renew?	**Effective:**____ /____ /____ **Renews:** ____ /____ /_____
5. Deductible met so far this year	**$**_____.____
6. Is Pre-authorization Needed? *(for some plans, authorization is needed only after a certain number of sessions)*	**No** _____ **Yes** _____ **Needed After Visit #**_____ ▪ **If Yes: Auth # :**_____ ▪ **# of Sessions Authorized:**_____ ▪ **Start:**_____ /_____ /_____ **Expires:**____/____ /_____
7. Claim form: HCFA/CMS-1500?	**Yes** _____ **No** _____
8. Out-of-pocket Maximum (amount client pays before the plan starts paying 100%)	
9. Claims address for EAP or MENTAL HEALTH claims	
10. Is CPT code 90847 (couples/family therapy) **covered?**	**Yes** _____ **No** _____
11. Am I a network provider for the plan?	
OUT-OF-NETWORK PROVIDERS: **12. Is my license covered?** **13. Is my fee within the plan's UCR** (Usual, Customary, Reasonable fee)? *Have your most common CPT codes and your fees for each ready*	**Yes** _____ **No** _____ **UCR: CPT CODE:**_____**: $**_____ **CPT CODE:**_____**: $**_____ **CPT CODE:**_____**: $**_____