

CHECKING COVERAGE: 14 ESSENTIAL QUESTIONS

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

Client: _____ I.D. # : _____
 Subscriber (if other): _____ Group:# _____
 Client Birthdate: ____ / ____ / _____ Relationship to Subscriber: _____
 Subscriber's Employer _____
 Insurance Phone Number (The card may say "MH/SA Benefits," "Eligibility and Benefits," For Pre-Authorization," "Member 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. When Do Benefits Start & Renew?	Effective: ____ / ____ / ____ Renew: ____ / ____ / ____
5. Deductible met so far this year	\$ _____.
6. Is Pre-authorization Needed? <i>(for some plans, authorization is needed only after a certain number of sessions)</i>	No ___ 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 per year before 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. Is telehealth covered? At same rate as in-person? Video and phone? Are client copays & deductibles the same? What modifier/Place of Service code is needed? Is preauthorization needed?	
12. Am I a network provider for this client's specific plan/account?	Yes _____ No _____
EXTRA: OUT-OF-NETWORK PROVIDERS:	
13. Is my license covered?	Yes _____ No _____
14. Is my fee within the plan's UCR (Usual, Customary, Reasonable fee)?	UCR: CPT CODE: _____ : \$ _____ CPT CODE: _____ : \$ _____ CPT CODE: _____ : \$ _____