

INSURANCE VERIFICATION WORKSHEET

As a healthcare provider, my relationship is with you, not with your insurance company. Your insurance is a contract between you, your employer and the insurance company. I am willing to bill insurance on your behalf, but I need your help to bill correctly. This worksheet gives me complete and accurate insurance information. I greatly appreciate your help with this.

All clients must complete this worksheet prior to their first session. Bring it with you to your first session.

CLIENT INFORMATION:

Client Name: _____ Insured Person's Name: _____
Parent Name (if child is client): _____ Insured's Employer: _____
Client's Social Security Number: _____ - _____ - _____ Insured's Social Security Number: _____ - _____ - _____
Client's Date of Birth: _____ / _____ / _____ Insured's Date of Birth: _____ / _____ / _____

INSURANCE INFORMATION (can be found on your insurance card):

Insurance Company: _____ Plan/Group #: _____
Claims Address: _____ Insured's ID #: _____
(mental health claims) Street (may be SSN, Member #, or Policy #)
City State Zip Claims Phone #: (_____) _____
(mental health claims – it may be different than other claims)

DETAILED BENEFITS INFORMATION (very important - please call your insurance company directly):

This section of the worksheet will help you better understand your current benefits and coverage and help me bill correctly.

- What telephone number did you dial? **Phone #** : (_____) _____
➤ Who did you talk to? **Contact Name**: _____ **Date/time of call**: _____

Say to the representative, "I'm calling to clarify my coverage for outpatient mental health benefits."

Ask enough questions to complete all the remaining information. Incomplete information will require additional phone calls.

- "Is my therapist, Kim Pollock, LPCC, in-network for me" YES NO
❖ If NO, then ask "Does my policy allow me to choose my own therapist?" YES NO
* For Couples Only - "Does my policy cover marital counseling?" YES NO

Then ask about your insurance policy's:

- **Effective date of policy?** _____/_____/_____ **Is your plan a(n):** HMO PPO EPO Other: _____
➤ **Copay?** _____ % or \$ _____ / session. Whichever is less.
➤ **Deductible?** NO YES - Amount of Deductible: \$ _____ / family OR individual?
Deductible per calendar year? NO YES - Month deductible begins: _____
Has any deductible been met for this year? NO YES - how much? \$ _____
➤ **Is pre-authorization needed?** NO YES – pre-authorization #: _____
➤ **Any benefits used to date?** NO YES – describe: _____
➤ **# of mental health visits allowed per calendar year?** _____ **# allowed per 24 consecutive months?** _____
beginning which month? _____
➤ **How many mental health visits remain for this year?** _____

❖ **Failure to complete this form will result in you being charged the full-fee at time of service for first session** ❖