

# FOR CLIENTS: CHECKING YOUR COVERAGE TO SEE AN OUT-OF-NETWORK THERAPIST

## BEFORE CALLING INSURANCE: INFO TO GET (SOME IS ON YOUR INSURANCE CARD)

1. Insurance I.D. #: \_\_\_\_\_ Group #: \_\_\_\_\_
2. Primary Subscriber on the Insurance: \_\_\_\_\_
3. Your Relationship to Primary Subscriber: \_\_\_\_\_
4. Primary Subscriber's Birthdate: \_\_\_\_/\_\_\_\_/\_\_\_\_ Your Birthdate: \_\_\_\_/\_\_\_\_/\_\_\_\_
5. Subscriber's Employer \_\_\_\_\_
6. Insurance Plan Phone Number (The card may say "Member Services," "MH/SA Benefits," "Behavioral Health," "Mental Health Coverage," "Eligibility and Benefits," or simply "Customer Service"): \_\_\_\_\_

## THE CALL: WHAT TO ASK THE INSURANCE COMPANY

NOTE YOUR CALL DATE: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ REPRESENTATIVE NAME \_\_\_\_\_

<b>1. I am seeking outpatient mental health benefits in a professional office setting (or via telehealth). Does my plan cover out of network providers for this service? If so, what is the coverage? What is my coinsurance?</b> (this is the percentage of the fee you will have to pay for the services)	
<b>2. For telehealth:</b> Is the coverage temporary? If so, until when?	
<b>3. What is my Out-of-Network deductible?</b> (The deductible is the amount you must yourself before the plan begins paying at all). You may have a separate deductible for in-network providers and one for out-of-network providers.	
<b>4. How much of the out-of-network deductible has been met so far this year?</b>	
<b>5. (If you know your therapist's fee): My therapist charges \$ _____. Is this within the Allowed Amount or UCR (Usual, Customary, and Reasonable Fee) for an Out-of-Network Provider? If not, what is the Allowed Amount?</b> (Some plans may cap the amount they allow, and reimburse based on this, but may not disclose the Allowed Amount)	
<b>6. Is my therapist's license covered by your plan?</b>	
<b>7. Are there any limits to the number of sessions per year?</b>	
<b>8. When do benefits start and renew</b> (you want to know when your deductible renews)? <b>Is my coverage active?</b>	Effective: ____/____/____ Renew: ____/____/____
<b>9. How do I submit invoices to the plan for reimbursement? Do I need to get a form to attach them to? What is the address where I would send MENTAL HEALTH claims?</b>	
<b>10. What is the Out-of-pocket Maximum?</b> (The amount you must pay each year before the plan starts paying 100% for health expenses)	
<b>11. Is CPT code 90847 (couples / family therapy) covered in case I might need this?</b>	Yes _____ No _____
<b>12. Can you give me a Call Reference Number for this call?</b>	