New Reflections Counseling

Client Mental Health Insurance Verification Worksheet

This document is intended to help you in determining your mental health insurance benefits. We recommend you contact your insurance plan directly. It outlines questions to ask when you call your insurance provider in order to better understand your health plan benefits.

Please complete this worksheet prior to your first session and bring it with you.

CLIENT INFORMATION

Client Name: ____________________

Parent Name (if child is client): _________

Client's Date of Birth: ___/___/_______

Insured Person's Name: _____________

Insured's Employer: ________________

Insured's Date of Birth:___/___/_______

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

Insurance Company: _______________

Claims Address: __________________
(mental health claims) Street

____
City State ZIP

Plan/Group #: _____________________

Insured's ID #: _____________________

Claims Phone #: (____) _____________
(mental health 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, **Nickie Cole LCSW**, 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? ___________