Patient Benefit Verification

Referral Type: EAP____ Insurance____ Both____

Patient's Name: ______________________________ DOB: ___/___/______ SSN: ______-____-_______

Primary Insurance Co. ______________________________ Secondary Insurance? **Yes No**

Policy Holder ______________________________ (If yes, fill out Secondary Insurance form)

Insurance ID# ______________________________ Group # ______________________________

Original Effective Date of Policy___/___/______ Is this policy current? **Yes No**

Type of Insurance: **HMO PPO POS Other** ________________

Is this policy managed? **Yes No**

If managed, Managed Care Co. ______________________________

Pre-Existing Clause? **Yes No** If yes, how long is the waiting period? ____ (months) Has it been met? **Yes No**

CONFIRMATION # ______________________

Mail Mental Health Insurance Claims to: Carrier ______________________________

PO Box ______________________________

City/State/ZIP ______________________________

Does this patient have EAP Benefits? **Yes No**

If Yes, Mail EAP Claims to:

Carrier ______________________________

PO Box ______________________________

City/State/ZIP ______________________________

EAP

CoPay $__________

Auth # __________

# of Visits/Year ______

Person from NHC Checking Benefits: ______________________ Date: ___/___/_____

Person Quoting Benefits: ______________________ Co. ______________________ Ph_____-_____-______

Additional Person(s) Quoting Benefits: ______________________ Co. ______________________ Ph_____-_____-______

Treating Doctor(s): ______________________ ______________________ ______________________

(Therapist) (Testing) (Psychiatrist)

Does policy have different benefits for serious vs. non-serious mental illness? If yes, get both sides of benefits:

IN NETWORK BENEFITS

SERIOUS DX NON-SERIOUS DX

DED: Ind._____ Met:_____ Ind._____ Met:_____

Fam._____ Met:_____ Fam._____ Met_____

Does DED include Gen. Med. and MH charges? **Yes No**

Calendar Year stars ___/___/______

Copay $________ $________

or Coinsurance ________% ________%

OOP Max $________ $________

then pays ________% ________%

# of Visits/Year ________ ________

Do visits include psychiatrists? **Yes No**

Visits used this Year______ ______

Lifetime Maximum ______ ______

Pre-Certification Required? **Yes No**

DX: Serious Non-Serious

Psychological Testing Covered? Yes No Yes No
(96101)

NeuroPsychological Testing? Yes No Yes No
(96118)

Any tests excluded (IQ, ADHD.etc.)______________________

What is the Co-Pay/Insurance? ______ ______

Is PreCertification Required? Yes No Yes No

to call for Pre-Certification:_____-______-_______

Testing Paid by the: Hour or Unit

How many therapy sessions would be used for 4 hrs of testing in one day? ______

OUT OF NETWORK BENEFITS? **Yes No**

SERIOUS DX NON-SERIOUS DX

DED: Ind._____ Met:_____ Ind._____ Met:_____

Fam._____ Met:_____ Fam._____ Met_____

Does DED include Gen. Med. and MH charges? **Yes No**

Calendar Year stars ___/___/______

Copay $________ $________

or Coinsurance ________% ________%

OOP Max $________ $________

then pays ________% ________%

# of Visits/Year ________ ________

Do visits include psychiatrists? **Yes No**

Visits used this Year______ ______

Lifetime Maximum ______ ______

Pre-Certification Required? **Yes No**

DX: Serious Non-Serious

Psychological Testing Covered? Yes No Yes No
(96101)

NeuroPsychological Testing? Yes No Yes No
(96118)

Tests included (IQ, ADHD) ______________________

What is the Co-Pay/Insurance? ______ ______

Is PreCertification Required? Yes No Yes No

to call for Pre-Certification:_____-______-_______

Testing Paid by the: Hour or Unit

How many therapy sessions would be used for 4 hrs of testing in one day? ______

Covered Services: Ind (90806)____ Grp (90853)____ Fam (90847)____ Marital (90847)____ Med Eval/MM (90805)____

Credential Level Accepted: MD ____ PhD ____ LCSW ____ LSW____ LCPC ____ LPC ____

AUTHORIZATIONS

Auth# ____________ Service Code(s): 90801 90806 90805 90847 96101 96118 Date: ___/___/______ to ___/___/______

Auth# ____________ Service Code(s): 90801 90806 90805 90847 96101 96118 Date: ___/___/______ to ___/___/______

Auth# ____________ Service Code(s): 90801 90806 90805 90847 96101 96118 Date: ___/___/______ to ___/___/______