Dr. Carol O'Saben

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MENTAL HEALTH/BEHAVIORAL HEALTH
INSURANCE BENEFITS VERIFICATION FORM

Patient's Name: _____ **DOB:** _____
Policy Holder's Name: _____ **DOB:** _____
(if different from patient)
Policy Holders SSN: _____

Primary Insurance/Behavioral Health Insurance Plan: (*Note: This may be different from your medical health benefit plan. Be sure to ask!)*

_____
Member ID#: _____ **Group #:** _____
Dependent's ID#: _____
Effective Date of Policy: _____ **Expiration Date of Policy:** _____

Questions for your Insurance Provider:

1) Do I have mental/behavioral health coverage? ☐ Yes ☐ No
   (*If YES, continue. If NO, there is no need to proceed; other payment arrangements must be made. Please contact therapist to discuss payment options.)*
2) Is my preferred therapist, Dr. Carol O'Saben, in network? ☐Yes ☐No
   (*If YES, go to In-Network Coverage. If NO, go to Question 3.)*
3) Do I have Out of Network Benefits? ☐Yes ☐No
   (*If YES, go to Out-of-Network Benefits, below. If NO, there is no need to proceed; other payment arrangements must be made. Please contact the therapist with whom you want to work to discuss payment options.)*

In-Network Coverage

4) What is my co-pay amount? $_____
5) Do I have a deductible? ☐Yes ☐NoWhat is my deductible? $_____

(*Now proceed to Services Covered, below.)*

Out-of-Network Benefits

6) How much will I be reimbursed if I see an Out-of-Network therapist? _____
7) Do I have an Out-of-Network deductible? ☐Yes ☐No What is my deductible? $_____

Services Covered

8) Can you please verify that individual therapy is covered under my policy? ☐Yes ☐No
9) Can you please verify that individual therapy provided through a telemental health platform is covered under my policy? ☐Yes ☐No

Services Authorized

10) Do I need authorization to receive any of these services? ☐Yes ☐No
    If YES, What is my authorization number? _____
11) How many sessions are authorized? _____