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 Dr. O'Saben to discuss payment options.)*
2) 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 Dr. O'Saben to discuss payment options.)*

Out-of-Network Benefits

3) How much will I be reimbursed if I see an Out-of-Network therapist? _____
4) Do I have an Out-of-Network deductible? ☐Yes ☐No
a) What is my deductible? $_____ b) How much remains on my deductible? _____

Services Covered

5) Can you please verify that individual therapy is covered under my policy (CPT code: 90837)? ☐Yes ☐No
6) Can you please verify that individual therapy provided through a telemental health platform is covered under my policy (CPT code: 90837-GT)? ☐Yes ☐No

Services Authorized

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