

# CHECKING COVERAGE: 12 ESSENTIAL QUESTIONS

## BEFORE CALLING INSURANCE: INFO TO GET FROM THE CLIENT / CARD

Client: \_\_\_\_\_ I.D. # : \_\_\_\_\_  
 Subscriber (if other): \_\_\_\_\_ Group:# \_\_\_\_\_  
 Client Birthdate: \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_ Relationship to Subscriber: \_\_\_\_\_  
 Subscriber's Employer \_\_\_\_\_  
 Insurance Phone Number (The card may say "MH/SA Benefits," "Eligibility and Benefits," For Pre-Authorization," "Member Service"): \_\_\_\_\_

## THE CALL: WHAT TO ASK THE INSURANCE COMPANY

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

Ask for outpatient mental health benefits. Tell them if you're a network or out-of-network provider

<b>1. Is telehealth covered?</b> For how long? Video and phone? What modifier/Place of Service code is needed?	
<b>2. Copayment</b> (flat fee) or <b>Coinsurance</b> (percentage) for telehealth, and office visits: Is this being waived for telehealth? Until when?	
<b>3. Deductible</b> (if applicable): Is this being waived right now? Until when?	
<b>4. Does client have unlimited sessions?</b>	
<b>5. When do benefits start &amp; renew?</b>	<b>Effective:</b> ____ / ____ / ____ <b>Renew:</b> ____ / ____ / ____
<b>6. Deductible met</b> so far this year	\$ _____. ____
<b>7. Is Pre-authorization needed?</b> (for some plans, authorization is needed only after a certain number of sessions)	No ___ Needed After Visit # _____ ▪ If Yes: Auth#: _____ ▪ # of Sessions Authorized: _____ ▪ Start: __ / __ / __ Expires: __ / __ / __
<b>8. Out-of-pocket maximum</b> (amount client pays per year before plan starts paying 100%)	
<b>9. Claims address or electronic payer ID</b> for EAP or MENTAL HEALTH claims	
<b>10. Are CPT codes 90847/90846</b> (couples and family therapy) covered?	Yes _____ No _____
<b>EXTRA: OUT-OF-NETWORK PROVIDERS:</b> <b>11. Is my license covered?</b>	Yes _____ No _____
<b>12. Is my fee within the plan's UCR</b> (Usual, Customary, Reasonable fee)?	UCR: CPT CODE: _____ : \$ _____ CPT CODE: _____ : \$ _____