

# Behavioral Health Insurance Verification Form

As a patient at Afg Guidance Center, you are responsible for contacting your health insurance company to confirm the details of your coverage. Being informed allows you to plan your health care accordingly and avoid unexpected bills.

Client:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Step 1:** Call the customer service number on your insurance card and ask for a customer advocate. You will need to provide him/her with your child’s name, birthday and your policy/group number.

Date of Call:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Representative Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Call Reference Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Step 2:** Does your insurance company manage your mental health benefits or is another company subcontracted to manage my mental health benefits?

Name of company that manages behavioral health coverage and policy number if different from medical coverage:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Step 3:** Is Afg Guidance Center in network for my behavioral health insurance? Yes No

If Afg Guidance Center is in network ask for **“In Network benefits.”** If Afg Guidance Center is **“Out of Network”**, you will responsible for paying for the total cost of the services provided and may seek reimbursement from your insurance company. Ask what your “Out of Network Benefits” are as well as if you need a referral from a “PCP” for the assessment.

**Step 4:** Ask the below questions for **In Network** and **Out of Network** Benefits. (Circle one)

What is my Deductible Amount: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How much of my Deductible is paid to date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is there a Co-pay (due at the time of service and amount): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is there Co-Insurance: Yes or No What % do I pay? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Maximum # of visits per year: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does my plan run on a calendar year? From \_\_\_\_\_\_\_\_\_\_\_\_ to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Exclusions of Coverage for patient:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Step 4:** Is Out-Patient Psychiatry Services provided in an office setting covered? Yes No

**CPT Codes for Psychiatry: 90792, 99212, 99213, 99214, 99215, 90833, 90836, 90838, 99202, 99204, 99205**

Is Out-Patient Therapy services provided in an office setting covered? Yes No

**CPT Codes for therapy: 90791, 90837, 90834, 90832, 90846, 90847, 90853**

Is Out-Patient Psychological Testing, in an Office Setting Covered? Yes No

**CPT Codes used for Testing: 96105, 96125, 96110, 96112, 96113, 96127, 96116, 96121, 96130, 96131, 96132, 96133, 96136, 96137, 96138, 96139, 96146**

Is Out-Patient Neurofeedback Assessment & Therapy in an office setting covered? Yes No

**CPT Codes for Neurofeedback: 90791, 95813, 95957, S8040 and 90837**

**Step 5:** Does my insurance require preauthorization for any of the above services?

If yes, please have a copy of the form faxed to **847-853-0230** or emailed to **guidance@afgfamily.com.** If an online copy of this form is available please ask for the website address and provide this information to your evaluator.

If authorization is required, therapy or testing cannot begin until the authorization form is completed. Failure to notify your evaluator of the need for authorization for services at Afg Guidance Center results in you assuming responsibility for the cost of the services provided.

Finally, verification of services or the authorization for services from your insurance company does not guarantee the payment of benefits. You can also ask your customer advocate to fax you a copy of your explanation of benefits for your review.

Signature of Guarantor:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_