

Services are in an Outpatient, Office setting.

Client Outpatient Mental Health Benefits

Client Name _____ Date of Birth _____

Insured Name _____ Insured DOB _____

Insurance Company _____ Insurance Phone # _____

Effective Date _____ ID # _____ Group# _____

Assigned Therapist: _____ In or Out Network? _____

Insurance Network Name: _____ Seen in Iowa or Nebraska? (circle) _____

Insurance Representative Name _____ Date _____

In Network Co-Pay _____ Out Network Co-Pay _____

In Network Coinsurance _____ Out Network Coinsurance _____

In Network Deductible _____ Out Network Deductible _____

Has my deductible been met? _____ Amount Remaining: _____

Individual Deductible \$ _____ Family Deductible \$ _____

Out of Pocket maximum: _____ Comment: _____

What percentage does the insurance pay? _____ What percentage do I pay? _____

Does my policy cover an LMHP (licensed mental health provider) or PLMHP? _____
(PLMHP=provisionally licensed mental health provider)

Is an MD/PhD Supervision or Referral Needed? YES or NO _____

Does my policy cover family sessions? With client present? YES or NO _____

Without client present? YES or NO Does it cover marriage counseling? YES or NO

Can I be seen for more than one (1) session per day? YES or NO _____

Is an authorization needed for outpatient mental health? In-network? ___ Out Network? ___

Authorization # _____ Auth Start/End Dates: _____

What sessions are covered on the Auth? _____

Amount I will pay each session is: _____

Notes: _____