INSURANCE BENEFITS INFORMATION FORM

To verify your mental/behavioral health coverage, please call the customer service number on your insurance card to complete the following information before your first appointment.

Client's Name: _____

Client's Date of Birth: _____ Client's Soc. Sec. #: _____

Policy Holder's Name (if different from client): _____

Policy Holder's Date of Birth: _____ Policy Holder's Soc. Sec. #: _____

Name of Primary Insurance - Behavioral Health Insurance Plan: _____
Note: this may be different from your physical health insurance plan

Member ID#: _____ Group #: _____

Name of Secondary Behavioral Health Insurance Plan (if applicable): _____

Member ID#: _____ Group #: _____

Do I have mental/behavioral health coverage? ____yes ____no *(If no, STOP….If yes, continue)*

Name of Therapist: _____

Is this therapist in network? ____yes ____no (*If YES, complete* ***In-Network Coverage*** *below)*

If NO, New Directions will provide you with a superbill you can use to file for possible reimbursement.

In-Network Coverage:

What is my copay/coinsurance amount? $_____

Do I have a deductible? __yes __no If YES, what is my deductible amount? $_____

Services Covered:

Are the following services covered under my policy?

- Individual Therapy (CPT Codes – 90834 & 90837) __yes __no & __yes _no
- Family Therapy (CPT Code – 90846 & 90847) __yes __no & __yes __no
- Pre-Marital Counseling, Couples & Marital Therapy (CPT Code – 90846 & 90847) __yes __no
  - Diagnosis Code: Z63.0 (Relationship Distress with Spouse or Intimate Partner) __ yes __no
- Group Therapy (CPT Code – 90853) __yes __no
- Psychological Testing (CPT Code – 96101) __yes __no

Authorization:

Is an authorization required? ____yes ____no
If YES, what is my authorization number? _____ # of sessions authorized: _____

Claim Information:

Claims address: _____

_____