Insurance Verification Worksheet

Client Name: __________________________ Parent Name: (if child is client) __________________________

Insurance Information: Please phone your Insurance Company and fill out this form the best you can. This is very helpful information if you are unfamiliar with your coverage.

Name of Insurance: __________________________________________ Phone: (________)_______________________
Claims Address: _____________________________________________________________________________________
Insured's Name: ___________________________________________ ID #: ___________________________________
Plan/Grp #: _________________________________________________________________________________________

When you call, be sure to write down the name of the person that you talk to for later reference.

HMO Contact Person: __________________________ Date & Time of call: __________________________

Say, “I’m calling to clarify my benefits and coverage for out-patient mental health.” (They will ask for your member ID #)
Ask enough questions to complete all of the information. Incomplete information will require another phone call.

Is my therapist, ________________________, or Olive Branch Counseling Center, on the Participating Provider List? (Name your therapist; you may find that information on your insurance’s website, but do remember that the website might not be up to date).

If ________________________, or Olive Branch Counseling Center, Inc. is NOT on their panel, then ask these questions:
“Does my policy allow me to choose my own therapist?” Yes No
“Can I go outside of the panel or the provider list?” Yes No (If so, “Is my coverage different? How?”)

Then ask: “What is my:
Copay: ________% or $ __________/session. Whichever is less. Effective Date of Policy: __________
Deductible? No Yes Amount of Deductible $ ___________ / family or individual?
Deductible Per Calendar Year? Yes No Month Deductible Begins __________
Has any Deductible been met for this year? No Yes If yes, how much? __________
Is Pre-authorization needed? No Yes Any benefits used to date? Yes No
# Visits allowed per calendar year __________
# Visits allowed per 24 Consecutive months __________ Beginning: __________