**OLIVE BRANCH PSYCHOTHERAPY**

*Dr. Stephen R. Parrish DMFT, LCPC*

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# 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/Group #: ______________________________________________________________________

**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** Dr. Stephen R. Parrish DMFT. LCPC **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 your therapist of choice is NOT on their panel, then ask these questions:

**"Does my policy allow me to choose my own therapist?"**

**"Can I go outside of panel or the list?"** (If so, **"Is my coverage different, and what difference?"**)

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? ☐ No ☐ Yes 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? ☐ No ☐ Yes

Number of visits allowed per calendar year _______ # Visits allowed per 24 Consecutive months _______

Beginning: ______________