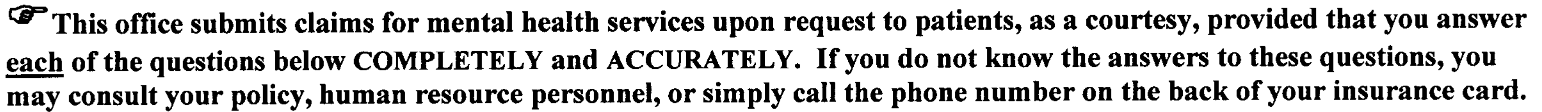
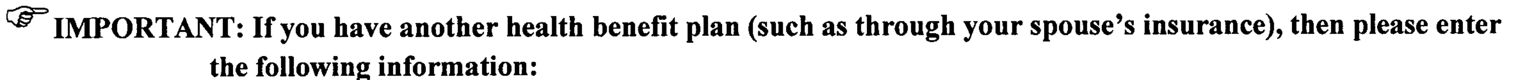
HEALTH INSURANCE INFORMATION SHEET ©

COMPLETE THIS FORM ONLY IF YOU WANT YOUR INSURANCE TO PAY FOR YOUR SESSIONS


This office submits claims for mental health services upon request to patients, as a courtesy, provided that you answer each of the questions below COMPLETELY and ACCURATELY. If you do not know the answers to these questions, you may consult your policy, human resource personnel, or simply call the phone number on the back of your insurance card.

1. What is the insured's full name? ____________________ ____________________
2. What is the insured's birthdate? ____________________ (enter month, date, and year)
3. What is the insured's insurance company?____________________
4. Who is the insured's insured's employer? ____________________
5. What is the insurance policy's effective date? ____________________
6. Does plan cover mental health disorders treated by a Licensed Clinical Professional Counselor (LCPC) in Illinois? **YES NO** (Circle one) If *so, is supervision for the LCPC by a psychologist or psychiatrist required?* **YES NO** (Circle one)
7. Is a **referral** from an M.D. or another health care professional required for services covered by an LCPC? **YES NO** (Circle one) *If so, from whom can you get such a referral?* ____________________
8. Is **pre-authorization** of sessions required for outpatient mental health treatment? **YES NO** (Circle one) *If so, please provide the name of the organization and the phone number for requesting authorization of sessions:* *Organization* ____________________ *Phone number:*____________________
9. Is there a **pre-existing benefit limitatation**? **YES NO** (Circle one) *If so, describe:* ____________________
10. What is the **co-payment** amount required for each outpatient mental health visit? ____________________
11. What **percentage** of the outpatient mental health fee is paid by insurance company per visit?____________
12. Does this plan have a **provider panel**? **YES NO** (Circle one) If so, what is the rate for **out-of-network** providers?__________
13. Is there a **deductible**? **YES NO** (Circle one) *If so, what is the amount of the* ***deductible?*** $____________ *If so, what is the balance to be satisfied towards the* ***deductable?*** $__________
14. Is there a **separate mental health deductible YES NO** (Circle one) *If so, enter amount here: $*__________
15. What is the **maximum number of visits** paid per year? ________________
16. Is there a **calendar year** maximum amount? **YES NO** (Circle one) *If so, please enter amount here: $*__________
17. Is there a **lifetime** maximum amount? **YES NO** (Circle one) *If so, please enter amount here: $*__________


IMPORTANT: If you have another health benefit plan (such as through your spouse's insurance), then please enter the following information:

Full name of the other insured:____________________
Birth date of the other insured (month, date, and year): ____________
Insured's employer and name of plan: ____________________

IMPORTANT! CLAIMS CANNOT BE SUBMITTED WITHOUT YOUR SIGNATURE BELOW AND EACH BOX IS CHECKED (✓).

- ☐ I have given accurate information regarding my insurance
- ☐ I will notify provider of any changes to my knowledge of my coverage.
- ☐ I will pay my full co-payment **before** each session begins.
- ☐ I authorize the release of diagnostic and other information to my insurance company that is reasonably necessary for the purpose of eligibility information and claims payment.
- ☐ I authorize payment of claims to the provider of mental health services.
- ☐ **I accept responsibility for any unmet deductibles and for any payments due to the mental health care provider that are NOT paid by my insurance company.**

I, the undersigned, agree to each of the above statements that are checked.

______________________________ ____________________
Signature of Patient or Authorized Person *Date*

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