Insurance Information Form

I will gladly submit claims for my outpatient mental health services provided that each question below is answered completely and accurately. Please call the phone number on the back of your insurance card and fill in the blanks below.

1. What is the insurance policy's effective date? _____
2. Does the plan cover outpatient mental health services by a **Licensed Clinical Professional Counselor (LCPC)** in Illinois? **YES NO** *(Circle one)*
3. Is a **referral from an M.D.** required for services covered by an LCPC?
   YES NO *(Circle one)*
   If so, from what doctor can you ask for such a referral? _____
4. Is **pre-authorization** of sessions required for outpatient mental health treatment? **YES NO** (Circle one)
   If so, please provide the organization and the phone number for requesting authorization of sessions:
   Organization:_____Phone number:_____
5. What is the **copayment amount** required for each outpatient mental health visit? _____
6. Is there a **deductible** for outpatient mental health? **YES NO** *(Circle one)*
   If so, what is the amount of the **deductible?** $_____
   If so, what is the **balance** to be satisfied towards the unmet **deductable?** $_____
7. Is there a **separate mental health deductible? YES NO** *(Circle one)*
   If so, enter amount here: $_____
8. What **percentage** of the outpatient mental health fee is paid by insurance company per visit?_____
9. Does this plan have a **provider panel**? **YES NO** *(Circle one)*
   If so, what's the **rate** paid for **out-of-network** providers?_____
10. Is there a **calendar year** maximum amount? **YES NO** *(Circle one)*
    If so, please enter amount here: $_____
11. Is there a **lifetime** maximum amount? **YES NO** (Circle one)
    If so, please enter amount here: $_____
12. What is the **maximum number of visits** paid per year? _____

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 payment / copayment **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 Dr, Scotty Lownsdale, 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*