Insurance Information Form

THIS FORM IS DESIGNED FOR YOUR CONVENIENCE TO HELP YOU FIND OUT IF YOUR HEALTH INSURANCE PLAN COVERS OUTPATIENT MENTAL HEALTH SERVICES PROVIDED BY DR. SCOTT LOWNSDALE. JUST 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. For **ILLINOIS** residents: Does the plan cover outpatient **ONLINE** mental health services by a **LICENSED CLINICAL PROFESSIONAL COUNSELOR (LCPC)** in Illinois who would be **OUT OF NETWORK** and whose office is **OUT OF STATE (**located in Colorado)? **YES NO** *(Circle one)*
3. For **COLORADO** residents: Does the plan cover outpatient mental health services by a **Licensed Professional Counselor (LPC)** in Colorado? **YES NO** *(Circle one)*
4. Is a **referral from an M.D.** required for outpatient counseling services? **YES NO** *(Circle one)*
   If so, from what doctor can you ask for such a referral? ________________________________
5. 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:____________________
6. What is the **copayment amount** required for each outpatient mental health visit? _____________________
7. 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 **deductible?** $__________
8. Is there a **separate mental health deductible?** **YES NO** *(Circle one)*
   If so, enter the amount here: $__________
9. What **percentage** of the outpatient mental health fee is paid by the insurance company per visit?____________
10. Does this plan have an in-network **provider panel**? **YES NO** *(Circle one)*
    If so, what's the **rate** paid for **out-of-network** providers?__________
11. Is there a **calendar year** maximum amount? **YES NO** *(Circle one)*
    If so, please enter the amount here: $__________
12. Is there a **lifetime** maximum amount? **YES NO** (Circle one)
    If so, please enter the amount here: $__________
13. What is the **maximum number of visits** paid per year? _______________
14. My mental health care provider does NOT submit claims and requires payment out-of-pocket on the date of service. Will my health insurance plan reimburse me for receipts that he provides to me that include his state license information, his NPI number, my diagnosis, date of service, and CPT code?

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: ___________________________

I authorize Dr. Scott Lownsdale to enter diagnostic information on receipts for services that my insurance company my deem necessary for eligibility information and claims payment.

_________________________________ ___________________
Signature of Patient or Authorized Person Date