HEALING minds Behavioral Health
Child, Adolescent, Family Counseling

A TRAUMA-FOCUSED COUNSELING PRACTICE

6502 Bandera Rd Ste. 202B | San Antonio, TX 78238
T: 210.418.2546 F: 210.429.7242 hmbhsa.com

MENTAL HEALTH/BEHAVIORAL HEALTH INSURANCE BENEFITS VERIFICATION FORM

Patient's Name: _____ D.O.B: _____

Patient's SSN: _____

Policy Holder's Name: _____ D.O.B: _____

Policy Holder's SSN: _____ Relationship to Patient: _____

Policy Holder's Employer: _____

Primary Insurance/Behavioral Health Insurance Plan/Payer _____
NOTE: This may be different from your medical health insurance plan

Member ID #: _____ Group ID #: _____ Ins. Phone #: _____

**PLEASE CALL THE 800 NUMBER ON YOUR INSURANCE CARD AND COMPLETE THIS FORM WITH A CUSTOMER SERVICE REPRESENTATIVE VIA TELEPHONE. IT IS IMPORTANT THAT YOU UNDERSTAND YOUR INSURANCE COVERAGE.*

1) "Do I have mental/behavioral health coverage?" □ YES □ NO
*(If **YES**, continue. If **NO**, there is no need to proceed, other payment arrangements must be made.* Please contact the therapist with whom you want to work to discuss payment options.)

2) "Is my preferred therapist _____ in network?" □ YES □ NO
(*If **YES**, go to **In-Network Coverage**, If **NO** go to question 3)*

3) "Do I have **Out-of-Network** benefits?" □ YES □ NO
*(If **YES**, go to **Out-of-Network** benefits. If **NO**, there is no need to proceed, other payment arrangements must be* made. Please contact the therapist with whom you want to work to discuss payments options.)

IN-NETWORK BENEFITS

4) "What is my co-pay amount?" $_____

5) "Do I have co-insurance?" □ YES □NO

6) If YES, "What is my co-insurance amount?" $_____

5) "Do I have a deductible?" □ YES □NO

6) If YES, "What is my deductible?" $_____

*(Now proceed to **Services Covered**)*

OUT-OF-NETWORK BENEFITS

7) "How much will I be reimbursed if I see an Out-of-Network therapist?" $_____

8) "Do I have an Out-of-Network deductible?" □ YES □ NO

If **YES**, "What is my out-of-network deductible?" $_____

SERVICES COVERED

9) "Please verify that the following services are covered under my policy?"

Individual Therapy (CPT Code 90834) □ YES □ NO Individual Therapy (CPT Code 90837) □ YES □ NO
Family Therapy (CPT Code 90846) □ YES □ NO Family Therapy (CPT Code 90847) □ YES □ NO
Group Therapy (CPT Code 90853) □ YES □ NO

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SERVICES AUTHORIZED

10) "Do I need an authorization to receive any of these services?" □ YES □ NO

If **YES**, "What is my authorization number?" _____ and

11) "How many sessions are authorized?" _____.

We hope that this information will help you better understand the mental health benefits of your insurance plan. Please arrive at least 15 minutes prior to your first appointment to complete any further paperwork and have your insurance ID card available as we will need to make a copy for your file.

Please note that missed appointments are **NOT** covered by your insurance plan. If you need to cancel or reschedule your appointment you must do so at least 24 hours in advance, otherwise you will be responsible to pay the full session fee. **Initial here** _____

Caregiver's Signature:_____ Date: _____

----------*DO NOT COMPLETE BELOW THIS LINE; TO BE COMPLETED INTERNALLY*----------

Effective date of policy: _____ Date of verification: _____

Network Status: IN OUT

Authorization # Effective Dates: _____ thru _____ Number of Visits: _____

Referral from PCP required: YES NO

Amount of Deductible Met: _____

Co-Insurance: _____

Yearly Visit Limitations: _____

Covered Services: Family Group Individual: 30 min 45 min 60 min

Spoke with: _____

CONTRACTED RATES

Initial Session: _____ Follow-up Sessions: _____