INNERCONNECT
COUNSELING

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Insurance Verification Form and Patient Information

Patient/Subscriber Information

Patient Name: _____ Date of Birth: _____

Home Address: _____

Subscriber Name (if different from patient name): _____

Relationship to Patient: _____ Subscriber's Date of Birth (if different): _____

Benefit Verification

Insurance Company Name: _____

Member I.D. Number (include letters): _____ Group #: _____

Insurance Phone # Called: _____

Spoke with: _____ Date: _____

Effective Date of Coverage: _____ Deductible: _____ Coinsurance: _____

Deductible Amount Met: _____ Copay: _____ Visit Maximum: _____

Ask: Are mental health services subject to the deductible? Y/N Other: _____

Ask: Does another insurance company administer mental health services? If Yes, Name of Company: _____

Ask: Is Candice Smith, LPC an in-network provider for my plan? Y/N

Ask: Is Authorization Required: Y/N If YES, Authorization Number: _____

Start and End Dates of Authorization: _____

Specific Codes Authorized: _____

Mail Claims to: _____

TELEMEDICINE SPECIFIC QUESTIONS

1. Does my plan cover teletherapy for mental health CPT Codes 90791, 90834, 90846, 90847, and 90837? Y / N

2. Does my plan prefer the modifier GT or 95 to be used? _____

3. If my plan does not cover teletherapy, can an exception be made given the COVID-19 pandemic? If an exception is made, is there an authorization code to provide my provider? AUTHORIZATION CODE: _____

4. Does my insurance plan REQUIRE a specific platform (e.g. Teledoc or MDLive) or can any HIPAA compliant platform be used? (My counselor will only be using the SimplePractice video platform that is HIPAA complaint)

a. _____Teledoc b. _____MDLive c. _____ Other REQUIRED platform: (list name)_____

d. _____ Any HIPAA complaint platform of provider's choosing

5. Will exceptions be made regarding the requirement of platforms given the COVID-19 pandemic? In other words, can my provider use SimplePractice video platform which is HIPAA compliant? Y / N

6. Are phone sessions covered? Y / N

7. Is my provider considered in network for teletherapy for my plan? If not, can an exception be made due to COVID-19?

_____ YES Covered _____Not Covered _____Exception can be made

REFERENCE NUMBER FOR THE CALL: _____

IMPORTANT – PLEASE READ:

*This form must be completed in full prior to the first appointment. If it is incomplete at the time of the appointment, your credit card on file will be charged the full rate for the session. I will then bill the insurance company and if they indicate your financial responsibility is lower than the full fee, I will apply a credit to your account to be used for payment of future services. Also note that I will bill based on what is indicated on this form. If your insurance company indicates that your financial responsibility is higher than what is indicated from this information, your credit card will be charged for the difference.

Insurance Coverage Financial Acknowledgement

If you maintain health insurance, part of your therapy expenses may be covered. You must check your policy or call your company. Your therapist will discuss insurance coverage, requirements and updates with you. In order to pay with insurance, you must complete the Insurance Verification Form and Patient Information prior to your first visit in order to identify covered services and benefits.

We will bill based on the information you provide. If your insurance policy does not cover the necessary services, or you do not receive prior authorization as required by your insurance company, or such authorization has not been timely obtained or has been denied by your insurance carrier, you agree that you will be responsible for the entire payment for services and may be billed as a private/self-pay.

Further, you understand that you are responsible for and agree to pay any copayments, deductibles, co-insurance, non-covered services or amounts in excess of your health insurance policy's annual and/or lifetime maximum benefit and understand that any such payment is due at the time of services.

_____	_____	_____
Client/Parent/Guardian Name (Print)	Client/Parent/Guardian Signature	Date