BENEFIT INFORMATION FOR CLAIMS

FOR OFFICE USE ONLY

(To Be Completed for All Insurance Clients)

Date _____

Insurance Company Name _____ DX _____

Client Name _____ Proc. Code _____

Client ID # _____

Client DOB _____

Therapist _____

Address for Mental Health Claims Submission:

_____

_____

_____

Phone Number for Mental Health Claims: (____) _____

IN NETWORK OUT OF NETWORK

Deductible _____ Co-Payment _____

Deductible Combined with Medical YES NO

Benefit Coverage:

Authorization required YES NO

Authorization # _____Number of Sessions Authorized _____

Authorized Date from _____ to _____

Special Instructions for Authorization or Treatment Plan:

_____

_____

EAP Sessions Available _____

Benefit Year Begins _____

Visits per Benefit Year _____