HEALTH INSURANCE BENEFITS WORKSHEET

YOU ARE RESPONSIBLE for finding out what your MENTAL HEALTH BENEFITS are and keeping track of what your financial responsibility will be for your therapy! If you do not obtain this information, we will need to collect the full amount for the initial visit which is $187. You will be reimbursed after your insurance has paid.

Insurance Company: _____ (If Blue Cross/Blue Shield see below)

Member# _____ Group # _____

Date Called: _____ whom you spoke to: _____

Copay: $ _____ Deductible: $_____

Does my deductible apply to mental health? _____

If so, how much of my deductible has been met? _____

When does my deductible start over? _____

Do I require a referral from my primary care physician? _____yes _____no

Do I require authorization? _____ Visit Limit? _____

If yes, how many have I used? _____

Where should my claims be mailed?

_____

_____

_____

Blue Cross/Blue Shield specific questions

1. **Do I have EPS benefits? _____yes _____no**
2. **Am I required to use an EPS provider to get in-network benefits? ____ yes _____no**
3. **Am I required to use a community health center? _____yes _____no**
4. **Do I require a referral from my primary care physician?-____yes _____no**

*****If you answer yes to ANY of these questions we are considered out-of-network, in most cases. Your insurance may pay 50% or less of the charges and your deductible may apply to your visit. If so, you will be required to pay any remaining balance.**

Patient Name: _____

Parent/Guardian Signature: _____ Date: _____