Family Counseling Associates 7526 E. 82nd St. Suite 150 Indianapolis, Indiana 46256 317-585-1060

Client Verification of Insurance Worksheet
Out-Patient, Out-of-Network, Behavioral/Mental Health Benefits.

Client Name: _____ Policy Holders Name:_____

Client DOB: _____Client Phone#_____ Policy Holder DOB: _____

Client Address:_____

Policy Holder Address if different than client: _____

Insurance Company: _____

Ins. ID: _____ **Group # _____Plan #_____**

Ins. Co. Phone: _____Policy Effective Date: _____

Out of Network Coverage? Yes or No **Number of annual visits** _____

Out Patient Mental/Behavioral Health Coverage? Yes or No *Do they cover the following therapy sessions*?

*Individual * Family *Marital *Medication Evaluation *Medication Management *Dietician

Out of Network Deductible: $ _____ Individual $ _____ Family

Coverage % UCR_____/_____ **Deductible met**? Y / N / Partially How much has been met: _____

Pre-Authorization required Yes or No if Yes Authorization Phone Number _____

Insurance Claims Address:_____

_____

Insurance Electronic ID#_____