Camp Psychological
& CONSULTING SERVICES

OUT-OF-NETWORK INSURANCE BENEFITS FORM

To verify your mental/behavioral health coverage, please call the customer service number on your PRIMARY insurance card and complete the following information:

Client's Name: _____ Client's Date of Birth: _____

Policy Holder's Name (if different from client): _____ Policy Holder's Date of Birth: _____

Name of Primary Insurance - Mental Health Insurance Plan: _____

***Note: Your mental health plan may be different from your physical health insurance plan**

Member ID#: _____ Group #: _____

Do I have mental/behavioral health coverage under my primary insurance plan? ____YES ____ NO

(If NO, STOP....If YES, continue)

Reimbursement Rate

Do I have a deductible? ____ YES ____ NO If YES, what is my deductible amount? $_____

How much will I be reimbursed if I see an out-of-network therapist? _____up to $_____ (allowable charges)

What percentage of my session will be paid by the insurance company once my deductible has been met _____%

Services Covered

Are the following services covered under my policy?

Individual Therapy (CPT Codes – 90834 & 90837) ____ yes ____ no & ____ yes ___ no

Family Therapy (CPT Code – 90846 & 90847) ____ yes ____ no & ____ yes ___ no

Pre-Marital Counseling, Couples & Marital Therapy (CPT Code – 90846 & 90847) ____ yes ___ no

- Diagnosis Code: Z63.0 (Relationship Distress with Spouse or Intimate Partner) ____ yes ___ no

Group Therapy (CPT Code – 90853) ____ yes ___ no

Authorization

Is an authorization required? ____ yes ___ no If YES, what is my authorization start/end dates? _____

What is my authorization number? _____ # of sessions authorized: _____

How can I obtain an outpatient treatment report form (to be completed by therapist)? _____

Claims Information

Claims submission address: _____

Do I need to submit my claim on a specific form? If so, which one and how do obtain the form?_____

Additional information required with claims: _____

Representative: _____ Customer Service #: _____