THERAPY INSTITUTE OF MICHIGAN LLC

Helping You Build A Life Worth Living

Behavioral Health Insurance Benefits

(Please Complete Prior to 1st Visit as much of the form as you can. If you are unsure, leave blank and you're therapist will assist you).

Patient's name: _____

Patient's date of birth: _____ Patient's ID/SS #: _____

Policy holder's name (if different from patient): _____

Policy holder's date of birth: _____ Policy holder's ID/SS #: _____

Policy holder's employer: _____

Address of policy holder's employer: _____

Name of MCO or other insurer: _____

Policy #: _____ Group #: _____ Renewal date_____

Name of any behavioral health subcontractor: _____ Phone number: _____

1. Is this specific patient covered under this policy? ❑ Yes ❑ No
2. Are services for treating "mental and nervous disorders" covered? ❑ Yes ❑ No

   Are services for treating "drug and alcohol disorders" covered? ❑ Yes ❑ No
3. Is "outpatient psychotherapy" or "outpatient mental health/behavioral health treatment" ❑Yes ❑ No

   for these disorders covered?
4. Will the insurance pay for these kinds of treatment? Individual psychotherapy ❑ Yes ❑ No

   Family therapy ❑ Yes ❑ No Psychological testing ❑ Yes ❑ No

   Drug and alcohol treatment ❑Yes ❑No Medication prescription and monitoring ❑ Yes ❑ No

   Group therapy ❑Yes ❑No ❑ Other: _____

5. Is this coverage Current ❑ Yes ❑ No ❑ Won't start until _____ of 20 ___

   ❑ Due to end on _____ ❑ Ceased as of _____? ❑ Yes ❑ No

6. Are services provided by a licensed psychologist, social worker, or other mental health professional covered?

   a. Are additional credentials required? (If yes, which?) ❑ No ❑ Yes

   b. Is referral by a physician required? ❑ No ❑ Yes

   c. Is supervision by a physician required? ❑ No ❑ Yes

   d. Is consultation with a physician required? ❑ No ❑ Yes
7. Is this therapist a "participating" or an "eligible" provider under this particular insurance plan? ❑ Yes ❑ No
8. Will this insurance plan pay providers who are "out-f-network"? ❑ Yes ❑ No

   If not, what are the additional costs to the client? _____

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9. Is there an exclusion for "preexisting" conditions? ❑Yes ❑No Are these present in this case? ❑ No ❑ Yes.
   What are they?: _____
   _____

10. Are there excluded diagnoses? (Ask about ADHD and learning disorders, ODD, borderline personality disorder, conduct disorder, chronic pain, or others as relevant.): _____
    _____

11. Is there a "copayment" that the client must pay for each treatment session? ❑ No ❑ Yes (If yes, how is it
    _____

12. Is there a deductible that must be paid by the patient before the insurance company will pay anything?
    ❑ No ❑ Yes. If yes, how much is it? $
    Is this deductible per year, per calendar year, per person/client, per family, per diagnosis (underline which) or

13. Will the insurer pay the entire amount of allowable charges (after the deductible) for mental health services, or

14. Is there a limit on the amount the insurance will pay for mental health services in a year or a lifetime?
    ❑ No ❑ Yes. If yes, $ per year and/or $ in lifetime. _____
    How much of this remains available? $ _____

15. Is there a limit on the number of visits/sessions per year or by diagnosis? ❑ No ❑ Yes, per year.
    ❑ Yes, by diagnosis: _____

16. If the spouse, the parents of a child patient, or the whole family is seen are these visits covered differently than
    _____

17. Will the policy pay for sessions longer than 1 hour? ❑ Yes ❑ No
18. If we must meet for two sessions on a single date, will insurance pay for it or for only a single session per day?
    ❑ Double session payment ❑ Only one session
19. Will insurance pay for more than one session per week? ❑ No
    ❑ Yes, but only sessions__ per week. ❑ Yes, as decided by the professional

20. Coordination of benefits: What rules apply if more than one insurance company is providing coverage for this

_____

_____

_____

21. Are there any other rules, requirements, forms, or procedures that we should be aware of?

_____

_____

_____

_____

22. Treatment(s) Authorization number _____

Authorizer: _____

_____

Starting date: _____ Number of sessions authorized: _____

Dollar limit: _____ Authorization renewal date: _____

23. Authorization to be faxed or mailed on _____ .

Authorization received? Yes on _____ Not received as of _____

24. Where are claims forms to be sent? _____

_____

Questionnaire for Determining Behavioral Health Insurance Benefits