East Bay Family Therapy

INSURANCE FORM

(Please Print)

Today's date:	PCP:

CLIENT INFORMATION

Client's last name:	First:	Middle:	Birth date: / /

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former name):	Sex: ❑ F ❑ M	Age:

Occupation:	Employer or School:	Employer or School phone no.: ( )

SUBSCRIBER INFORMATION

Last name:	First:	Middle:	Birth date: / /

Occupation:	Employer:	Employer address:	Employer phone no.: ( )

Group no.:	Policy no.:

Mental/Behavioral Health phone number (on back of card).	( )	General phone number (on back of card).	( )
Is this client covered by this insurance?	❑ Yes ❑ No		Co-payment: $
Client's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child ❑ Other

❑ No secondary insurance for client (if No, then skip to Billing Information)

Secondary insurance				
Subscriber's name:	Birth date: / /	Group no.:	Policy no.:	Co-payment: $

Mental/Behavioral Health phone number (on back of card).	( )	General phone number (on back of card).	( )
Client's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child ❑ Other

BILLING INFORMATION

(required if different than insurance information)

Person responsible for bill:	Birth date: / /	Address:	Home phone no.: ( )

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the clinician. I understand that I am financially responsible for any balance, no-shows or late cancellations. I authorize East Bay Family Therapy or insurance company to release any information required to process my claims. I also authorize East Bay Family Therapy to release necessary information to the emergency contact if a parent or guardian cannot be reached in a timely manner.

Client/Guardian signature *Date*

For Office use only. You don’t have to fill this part out.

Does the client have out-of-network benefits?
    What are the benefits?
How many visits are allowed each year?
    What defines a year (calendar, fiscal, date of first service)?
What is the maximum dollar amount covered each year?
What benefits have already been used this year?
What is the lifetime maximum number of sessions?
What is the lifetime maximum amount covered?
Are any diagnoses excluded from payment?
What are the parity diagnoses?
Is (marital, couples, family) therapy a covered benefit?

This client is covered by another policy, is this insurance primary and should it be billed first?

Do visits require precertification?
Has the precertification already been done for the client to see me?
    What is the approval number?
    How many sessions have been approved?
    What is the timeframe to use them?
    What are the allowed CPT codes for these services/
    Will a certification letter be sent to me?
    What is the process to precertify?
    What is the process to request future certifications?
What is the co-payment per session?
Is there a deductible?
How much is the deductible?
How much has already been paid?
When does the deductible start over?