Eating and Behavioral Health Associates, LLC

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Insurance Information Worksheet

I truly appreciate your choosing to come to me for psychological help. As part of providing high-quality services, we need to be clear about our financial arrangements. If you have health insurance, it may pay for a part of the cost of your treatment here. Please call your insurance company to answer questions below in part B and C.

A. Patient's name: _____ Birthdate:_____/_____/_____

Patient's SSN:_____-_____-_____

Address: _____

Home/mobile phone: _____

Occupation:_____Employer: _____

B. Primary Commercial health insurance carrier/company

Name of company: _____

Company address: _____

Company phone:_____Fax:_____

Name of policyholder (if not patient): _____

Policy Holder DOB (if different):_____/_____/_____Policy Holder Phone:_____

Policy Holder Address (if different)_____

Policy Holder Occupation _____Employer:_____

Identification#: _____ Policy/Group #:_____

Policy Holder SSN:_____-_____-_____Effective Date: _____/_____/_____

Please call your insurance company and ask the following prior to the first session:

1. Is there Outpatient Mental Health Coverage? _____Yes _____No
   If so, what type of coverage(s): ____Individual ____Group _____Marital _____Family

2. Are there any limits to mental health benefits, such as number of sessions, duration of session, type of session?:_____

3. Is pre-authorization necessary? _____Yes _____No

If yes, please request any required forms. _____ (check if requested/obtained)

4. Are there out-of-network benefits? _____Yes _____No

If yes, what are the details? _____

5. Is there a yearly deductible? _____Yes _____No

$_____per year for individual $_____per year for family

How much has been met to date? $_____

6. Is there a yearly out-of-pocket max? _____Yes _____No

$_____per year for individual $_____per year for family

How much has been met to date? $_____

7. Coverage Details: _____% covered for in-network provider _____% covered for out-of-network provider _____ # of sessions covered per year

8. Is there a co-pay or co-insurance amount that needs to be paid directly by the client at each appointment? How much is it? _____

C. Secondary Commercial health insurance carrier/company (if applicable)

Name of company: _____

Company address: _____

Company phone:_____Fax:_____

Name of policyholder (if not patient): _____

Policy Holder DOB (if different):_____/_____/_____Policy Holder Phone:_____

Policy Holder Address (if different)_____

Policy Holder Occupation _____Employer:_____

Identification#: _____ Policy/Group #:_____

Effective Date: _____/_____/_____Policy Holder SSN:_____-_____-_____

Please call your insurance company and ask the following prior to the first session:

1. Is there Outpatient Mental Health Coverage? _____Yes _____No
   If so, what type of coverage(s): ____Individual ____Group _____Marital _____Family

2. Are there any limits to mental health benefits?:_____

3. Is pre-authorization necessary? _____Yes _____No
   If yes, please request any required forms. _____ (check if requested/obtained)

4. Are there out-of-network benefits? _____Yes _____No
   If yes, what are the details? _____

5. Is there a yearly deductible? _____Yes _____No
   $_____per year for individual $_____per year for family
   How much has been met to date? $_____

6. Is there a yearly out-of-pocket max? _____Yes _____No
   $_____per year for individual $_____per year for family
   How much has been met to date? $_____

7. Coverage Details: _____% covered for in-network provider _____% covered for out-of-network provider _____ # of sessions covered per year

8. Is there a co-pay or co-insurance amount that needs to be paid directly by the client at each appointment? How much is it? _____