



# Insurance Company Questions

Health insurance policies are an agreement between you and your insurance company. To help you understand what coverage you can expect in relationship to outpatient psychotherapy (counseling), simply call your insurance company regarding outpatient behavioral healthcare and ask the following questions. Although not every area of treatment is covered on this form, it should clarify most questions, and be useful in submitting claims.

- Date I called my insurance company \_\_\_\_\_
- Name of the person who gave me the information \_\_\_\_\_
- Is my counselor in my network?  YES (answer questions 4-6)       NO (go to question 7)
- What are my **in-network** benefits?  
 Do I have a deductible?  NO       YES, what is my deductible? \_\_\_\_\_  
 Has my deductible been met?  YES       NO, what amount is left to be fulfilled? \_\_\_\_\_  
 Are there separate deductibles for medical and mental health?  YES       NO  
 When does my deductible begin? \_\_\_\_\_  
 How many visits do I have per year? \_\_\_\_\_  Calendar year OR  Contract year dates \_\_\_\_\_  
 What is my co-pay amount? \$ \_\_\_\_\_ OR co-insurance percentage? \_\_\_\_/\_\_\_\_  
 Any other benefits or limits that I should know about? \_\_\_\_\_  
 \_\_\_\_\_
- Does my policy require pre-certification or pre-authorization for treatment?  
 NO (proceed to #6.)  
 YES, how many visits will be authorized? \_\_\_\_\_ Authorization eff. dates? \_\_\_\_\_  
 Authorization number? \_\_\_\_\_
- Does my policy require a referral from a physician?  YES       NO  
 If YES, have you received the referral from my physician?  YES       NO

**Ask the following questions ONLY if your therapist is NOT in your network:**

- Do I have to choose a mental health provider within my network?  
 YES (contact Central College for a referral to a therapist in your network: 614-865-0513)  
 NO (ask if you have out of network benefits and complete section below)  
 Do I have an out of network deductible?  YES, what is my deductible? \_\_\_\_\_  NO  
 Has my deductible been met?  YES       NO, what amount is left to be fulfilled? \_\_\_\_\_  
 When does my deductible begin? \_\_\_\_\_  
 How many visits do I have per year? \_\_\_\_\_  Calendar year OR  Contract year dates \_\_\_\_\_  
 What is my co-pay amount? \$ \_\_\_\_\_ OR co-insurance percentage? \_\_\_\_/\_\_\_\_  
 Does my policy require pre-certification or pre-authorization for treatment?  YES       NO  
 If YES, how many visits will be authorized? \_\_\_\_\_ Authorization eff. dates? \_\_\_\_\_  
 Authorization number? \_\_\_\_\_