LIFE RECOVERY CENTER – HEALTH INSURANCE INFO FORM

We look forward to seeing you and will gladly file your counseling sessions with your insurance company; however, we do not verify coverage or call to get the information concerning your coverage for you. You must call the phone number(s) on your health insurance card to get the following information from your insurance company and **fax this completed form to us at (317) 887-3290 BEFORE** your first session. **Without ALL questions on this form completed, you will be responsible for the full session fee.**

Name:_______________________________________ Date of Birth: _______________ Phone:_______________

Insured's Name:____ SS #: ________________________

Name of Insurance Company:____ Effective date: ______________

Insured's ID number__________________________________Group Numbers: ____________________________

Please call the number on your insurance card and ask THESE questions:

1. What is the address for **MENTAL HEALTH** claims? ____

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2. Do I have **MENTAL HEALTH** benefits? __Yes __No **(if not, STOP)**
3. Is (give counselor's name) on my provider list? __Yes __No
4. If not, do I have an Out of Network benefits? __Yes __No (if yes, write what they are on back of form)
5. Do I have a separate Mental Health deductible? __Yes __No (Amount of deductible: ________)
   If applicable, how much of that deductible have I met? __N/A or $_____________
   Do I have Co-Insurance? __Yes How much?_______% __No
6. What is my copayment for mental health? $______________per session.
7. How many sessions are allowed per calendar year? ______________________
8. If applicable, do I have family, couple's, or marriage counseling benefits? __Yes __No
9. If applicable, my plan cover telehealth/teletherapy/online counseling as long as it is billed with the appropriate modifiers? __Yes __No
10. If applicable, does my coverage include services provided by a Licensed Clinical Addiction Counselor (LCAC)? __Yes __No
11. Is prior authorization needed for counseling? __Yes __No **(if not, STOP)**
12. Authorization number? _______________ How many sessions are authorized? ________________
13. For what dates are those sessions authorized? From: _______________ To: ______________

In signing, I authorize the release of any medical or other necessary information necessary to process claims.

PATIENT OR AUTHORIZED PERSON'S SIGNATURE:_____________________________**DATE:**_______

INSURED OR AUTHORIZED PERSON'S SIGNATURE:_____________________________**DATE:**______