**QUESTIONS TO ASK YOUR INSURANCE CARRIER BEFORE YOUR APPOINTMENT:**

Your Primary Insurance is: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Secondary: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Member #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ID#:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Member Services Phone #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date you Called: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Who you spoke to: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Verify with your insurance company if there would be coverage for the services your child needs: \_\_\_\_\_\_\_CPT 97530, 97110, 97112, 97535 \_\_\_\_\_\_\_\_\_\_\_

OT \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If there is coverage is there any exclusion? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. Do I have a co-payment or is there a percentage of the bill I will be responsible for? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3. Does my plan require a deductible be paid for the calendar year before the coverage begins? \_\_\_\_\_\_\_\_\_\_\_ What is the dollar amount? \_\_\_\_\_\_\_\_\_\_

4. Does my child have an out of pocket maximum that I pay per calendar year? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

5. Does my insurance plan cover only a limited number of sessions for each calendar year? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is there a requirement that I get a prior authorization and/or a referral before I see a clinician? Yes\_\_\_\_\_ No\_\_\_\_\_ If yes, who do I contact? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone#:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I have verified the above information and understand that I am responsible for any charges that the insurance does not cover. **Please sign below and return this form along with a copy of your insurance card and your completed paperwork.** Failure to complete and return this form may result in a delay in scheduling an appointment. Thank you for your cooperation.

Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_