**Door of Hope Counseling Center
INSURANCE VERIFICATION**

**Tax ID# 58-2334068**

**NPI Number 1447549142**

Patient’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB ­­­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance Company \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ID# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ EAP# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance Phone ( ) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Effective Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Name of Contact at Insurance Company: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Today’s Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Time of Call: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Is this an **in-network** claim? YES NO
2. Does the patient have an **HSA**? YES NO
	1. If yes, card number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
	2. Limit \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. **Does the patient have mental health coverage?** YES NO
4. Is this insurance a **HMO, PPO, or OTHER**? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
5. Is a **referral** required? YES NO
	1. If yes for #4, what is the **PCP’s name**? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
	2. If yes for #4, what is the PCP’s **phone number?** ( ) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
6. Is a **preauthorization** required? YES NO
7. What is the patient’s mental health **deductible amount**? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
8. What is the deductible for the **individual?** \_\_\_\_\_\_\_\_\_\_\_\_\_
	1. Has the **deductible for the individual** been met? YES NO
	2. If no, what portion of the **individual** **deductible** has been met? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
9. What is the deductible for the **family**? \_\_\_\_\_\_\_\_\_\_\_\_\_
	1. Has the **deductible for the family** been met? YES NO
	2. If no, what portion of the **family deductible** has been met? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
10. Is the **deductible** per calendar year? YES NO
	1. If no, when? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
11. What is the patient’s **Co-pay** $\_\_\_\_\_\_\_\_\_\_ or **Co-Insurance** \_\_\_\_\_\_% ?
12. What is the **maximum out-of-pocket** before insurance pays 100%? \_\_\_\_\_\_\_\_\_\_\_\_
13. Is there a **maximum** **number of visits** allowed annually? YES NO
	1. If yes, how many? \_\_\_\_\_\_\_\_\_\_\_\_\_
	2. If yes, how many visits have been used? \_\_\_\_\_\_\_\_\_\_\_\_\_\_
14. Is there a **lifetime maximum**? YES NO
15. Is there a **maximum dollar amount** paid per year? YES NO
	1. If so, how much? \_\_\_\_\_\_\_\_\_\_\_\_\_
	2. If yes, what amount has been used? \_\_\_\_\_\_\_\_\_\_\_\_\_\_
16. For this patient, do you pay for:

**90791 – Diagnostic** YES NO

**90834 – Individual** YES NO

**90847 – Family and Marriage** YES NO

**90832 – 30 minutes** YES NO

**90837 – 60 minutes** YES NO

**90899 – for telephone or distance counseling** YES NO

**98968 – for telephone or distance counseling** YES NO

1. Are there any **limitations**, restrictions or pre-existing conditions? YES NO \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
	1. Are there any **mental health** limitations, exclusions, etc.? YES NO

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1. What is the timely filing limit? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. What is the name, address and phone number for filing a mental health claim?

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