Insurance Benefit Information

Psychologist: Grant L Martin, PhD, Licensed Psychologist #596
Office Location: 555 Dayton St. Suite C, Edmonds, WA 98020
425-999-6285 FAX: 425-774-0690

Client's Name: _____

Client's relationship to Subscriber: Self Spouse Dependent

Subscriber Information:

Date of Birth: _____ Employer: _____

Insurance ID#: _____ Group #: _____
***(include any letters in front of ID #)

Insurance Information:

Mental and behavioral health benefits are different than traditional medical coverage. Your mental health benefits may be handled by a third party insurance company. The information is on the back of your card. It is your responsibility to call your insurance and complete the information required below. Without the information you may be required to pay in full at time of service until obtained. Co-pays are due at the time of service.

Medical Insurance Company: _____ Phone #: _____

Claims mailing address: _____

Mental Health Insurance Company: _____ Phone#: _____

Claims mailing address: _____

1) Ask your plan if the counselor you are seeing is in-network or out of network?

	Yes or No
In-Network	
Out of Network	
If out of network, do you have benefits?	

2) Please complete the following benefits table. Each insurance plan varies as to whether or not your deductible needs to be meet before they will pay your provider. Co-pay is due at the time of service.

		Applicable Yes or No
Co-pay	$	
Deductible	$	
Out of pocket max	$	
Reimbursement %	%	

3) You will need to ask if each of the following codes is covered under your plan and if authorization is needed:

CPI Code	Description	Yes	No	Authorization #
90791	Intake			
90833-90834	Routine sessions			
90837	45-60 min session			
90847	Family/Marriage Counseling			
96101	Psychological Testing			

Referral and Authorization

Referral:

4) Does your insurance require you to get a referral from your PCP provider? YES or NO
5) Do you have one if required? YES or NO

Authorization:

6) Did any of the CPT codes require authorization? YES or NO
7) If so, please obtain the authorization and indicate the following:

Authorization number: _____ Authorization date range: _____
Number of visits allowed: _____ CPT code: _____

I understand that services provided will be billed to my insurance company in a timely manner and that I will be sent a monthly statement regarding any balance due after my insurance has processed the claim(s). Your provider does accept debit and credit card in their office. Any questions or concerns I have will be addressed with the provider and/or his billing service (Revenue Concepts, 425-258-1880).

Client's Signature: _____ Date: _____

Printed name: _____

Guardian of Client Signature: _____ Date: _____

Printed name: _____