Powhatan Family Counseling
and Education Center
Dr. Judith Cain-Oliver, Licensed Clinical Psychologist
2156 Plainview Business Center · Powhatan, VA 23139
(804) 598-9577 · Fax (804) 598-0084

Insurance Benefits Form

Insurance companies often manage mental health benefits differently than general medical services. You must call your insurance company to ask about OUTPATIENT MENTAL HEALTH BENEFITS before services are rendered. Failure to do so could result in all charges incurred being your responsibility.

<u>You will need to call</u> the mental health or member services number on your insurance card. Use this form below to obtain the appropriate information. Ask the customer service representative the following questions and complete the entire form.

Patient's Name: _____
Insurance Company: _____
Telephone number you called: _____
Name of customer service representative: _____

Does the **Mental Health** portion of your coverage list Dr. Judith Cain-Oliver as participating in their provider network? _____
If not, will a portion of the services be covered by "out-of-network" benefits?_____
If "yes", what percentage will be covered?_____
When does your "benefit year" begin?_____
What is the amount of your yearly deductible?_____
What amount of the yearly deductible has already been met?_____
What is the copayment or coinsurance amount?_____

Is pre-authorization required for **Outpatient Mental Health** services?_____
If "yes", tell them the date of your first appointment and ask them to give you:
the Authorization Number: _____
the number of sessions authorized _____
dates of authorization starting _____through _____

What is the mailing address for **Mental Health**
claims?
(Do not assume the address on your insurance card applies to mental health.)

_____

_____

_____

We appreciate your help in providing accurate insurance information to our billing department to ensure correct and prompt payments.
I understand I may be responsible for full payment of all charges if this form is not completed as required.

_____ _____
Date Signature of Person Responsible for Payment