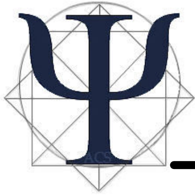

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BLUECROSS / BLUE SHIELD
QUESTIONS FOR INSURANCE COMPANY

Name: ____ Date: ______________________

Primary Insurance Company: ____

Relationship of Policy Holder to Client:

☐ Self ☐ Spouse ☐ Child

Insured's ID #: ____

Insured's Group #: ____

If you are a DEPENDENT on another person's insurance policy please provide the following information:

Policy Holder Name: ____

Policy Holder Date of Birth: _____ /_____ /_____

Policy Holder's Address (if different from your own):

____

____

PLEASE BRING A COPY OF YOUR INSURANCE CARD TO THE FIRST SESSION

Steps to determine your benefits:

- Call the customer service number for your plan, typically found on the back of your insurance card (use the number for Mental Health if they have it).

- Ask about whether your plan includes coverage for outpatient mental health treatment.

  If yes, inform them that you will be working with a provider who is empaneled with CareFirst and Anthem BC/BS. Be sure to mention that I am **a PPO provider (not an HMO provider)** with them. You will need the information included in the header of this document (e.g., provider name, NPI number, etc.).

  If no, you ***will not*** be able to use your insurance to pay for services. In this case, I would recommend contacting customer service a second time to confirm that the information you were provided during your initial inquiry was correct.

< continue on next page >

If it is confirmed that my services will be covered by your BC/BS plan, ask the following questions:

What is my copay/co-insurance? ______________________

Does my copay change based on the number of sessions I have had? **YES / NO**

If yes, please describe how my copays change based on the number of sessions.

____

Do I have an annual deductible that must be met? **YES / NO**

If yes, has my deductible been met yet this year? **YES / NO**

What is my annual deductible? ____________________________________

When does my annual deductible reset? ____________________________________

Do I need pre-authorization for services? **YES / NO**

If yes ask whether *you* are able to request the pre-authorization for services or if the provider must make the request?

If *you* are able to request the pre-authorization, what is the authorization number?

____

If *the provider* needs to request the pre-authorization, what is the process for doing so (e.g., phone number, website, etc.)?

____

____

Are there a maximum number of visits allowed per year? **YES / NO**

If yes, what is the maximum number? ____

Is there any other information I should know to ensure my insurance coverage for these services?

YES / NO

If yes, specify: ____

Record the name of the person you spoke with and the date of your telephone call.

Name: ____ Date: ___________________