



Dr. Kimberly Martin, HSPP

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Verification of Behavioral Health Insurance Benefits

Please complete the following information and return to Dr. Martin no later than your **SECOND** appointment.

Name: _____

Date of birth: _____

Client ID (completed by Dr. Martin) #: _____

Policy holder's name (if different): _____

Policy holder's date of birth: _____ Policy holder's ID#: _____

Policy holder's employer: _____

Address of policy holder's employer: _____

Name of MCO or other insurer: _____

Policy #: _____ Group #: _____ Renewal date _____

1. Are you covered under this policy? Yes No
2. Are services for treating "mental and nervous disorders" covered? Yes No
 Are services for treating "drug and alcohol disorders" covered? Yes No
3. Is "outpatient psychotherapy" or "outpatient mental health/behavioral health treatment" for these disorders covered? Yes No
4. Will the insurance pay for these kinds of treatment?

| | | | |
|--|--|--|--|
| Individual psychotherapy | <input type="checkbox"/> Yes <input type="checkbox"/> No | Psychological testing | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Family therapy | <input type="checkbox"/> Yes <input type="checkbox"/> No | Medication prescription and monitoring | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Drug and alcohol treatment | <input type="checkbox"/> Yes <input type="checkbox"/> No | Group therapy | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Group therapy <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Other: _____ | | | |
5. Is this coverage Current Yes No Won't start until _____ of 20 ____
 Due to end on _____ Ceased as of _____? Yes No
6. Are services provided by a licensed psychologist, social worker, or other mental health professional covered? Yes No
7. Is Dr. Martin a "participating" or an "eligible" provider under this particular insurance plan? Yes No
8. Will this insurance plan pay providers who are "out-of-network"? Yes No
 If not, what are the additional costs to the client? _____

9. Are there excluded diagnoses? (Ask about ADHD and learning disorders, ODD, borderline personality disorder, conduct disorder, chronic pain, or others as relevant.):

11. Is there a "copayment" that must be paid for each treatment session? No Yes (If yes, how is it calculated/amount?):

12. Is there a deductible that must be paid by the patient before the insurance company will pay anything? No Yes. If yes, how much is it? \$ _____

Is this deductible per year, per calendar year, per person/client, per family, per diagnosis (underline which) or some combination of these? _____

13. If the spouse, the parents of a child patient, or the whole family is seen are these visits covered differently than visits of the patient alone? No Yes If yes, how

14. Will the policy pay for sessions longer than 45 minutes? Does the policy pay for code 90837 Yes No

15. Coordination of benefits: What rules apply if more than one insurance company is providing coverage for this patient and claims are submitted to both companies? (Which has priority?) _____

21. Are there any other rules, requirements, forms, or procedures that we should be aware of?

Additional information: