Therapist's name: _____

INSURANCE INQUIRY

Client: _____	Subscriber (if other): _____
Address: _____	
Client's Date of Birth: _____/_____/_____	Subscriber's Date of Birth: _____/_____/_____
Client's relationship to the insured: _____	
Gender of Client: M _____ F _____	Gender of Subscriber: M _____ F _____
Diagnosis: _____ Description: _____	
Insurance Co.: _____	Ins. Phone#: _____
Client's ID#: _____	**Insured's ID#:** _____
Scan ins. card, if possible	
Call Date: _____/_____/_____	Spoke with: _____
Request "outpatient mental health benefits".	
Notes:	

	PARITY	**NON PARITY**
Co-payment (flat fee) or Co-insurance (percent)		
Deductible	Ind.: Family:	
Out-of-Pocket Max.	Ind.: Family:	
Sessions Allowed per year		
Effective Date of Coverage	_____/_____/_____	
When do benefits renew?	_____/_____/_____ Calendar Year _____	
Deductible met this year	$ _____._____	
Is Pre-auth. needed?	Yes _____ No _____	
CPT Code Covered	90791 _____ 90847 _____ 90837 _____ 90834 _____	
Insurance Pymt Goes To	Provider _____ Member _____	