Using Superbills for Reimbursement

What is a superbill?

- A form completed by your mental health provider that allows patients to be reimbursed directly from their health insurance companies.

- *Note:* A superbill does not guarantee that an insurance provider will pay for the services provided. Each insurance plan is different, and it is your responsibility to contact your insurance provider and find out exactly what will be covered.

Why does OneDay Counseling not bill my insurance company for me?

- Many professionals do not work directly with insurance companies, choosing rather to work independently.

- This ensures that your counselor makes clinical decisions that are purely based on professional expertise and not on health insurance policies.

- Additionally, OneDay Counseling does not bill insurance, we do not have to increase our costs to compensate for time spent managing paperwork. This keeps our services affordable for our clientele.

How do I find what my insurance company will reimburse for an out-of-network provider?

The only way to know for sure what your insurance company will pay is to ask them directly. Prior to starting work with a counselor who uses superbills, you should contact your insurance company to find out.

Here is how to contact them:

1. Call the customer service phone number listed on your card
2. Keep your insurance card handy as they will need your account information in order to answer questions about your specific plan.
3. Ask, “I want to work ti an out-of-network Counselor, how much will you reimburse me?” Be sure to inform them that One Day Counselors are licensed in the commonwealth of Virginia.
4. Inquire about reimbursement for counseling appointments.
5. Ask, “What is the best way to submit my claim with superbill?”
6. Be sure that your benefits are clear to you. *If anything is confusing, don’t be afraid to ask the same question twice.*

Mental Health Provider Services

Ruel Tyer, PhD, LPC
963 2nd Street SE
Charlottesville, VA 22902
434-566-0998
LIC# 0701006011
EIN# 20-1373563

Date: ___/___/_____

Patient Name: _____ DOB: ___/___/_____

Address: _____

Phone: _____ SSN: _____

Insured Name: _____

Insurance Company: _____

Group #: _____ Member #: _____

Dates of Visit/CPT Code:	# Visits @ Fee = Total
_____ 90837 Individual Therapy	____ @ $_____ = $ _____
_____ 90847 Family Therapy	____ @ $ _____ = $_____
_____ 90853 Group Therapy	____ @ $ _____ = $_____

Diagnosis Code: _____ Total Charges: $_____

Total Paid: $_____

I authorize the release of any medical information necessary to process this claim.

_____

Date Signature

_____

Date Signature of Provider