Agave Center

FOR JUSTICE IN MENTAL HEALTH

Guide to Verifying Insurance Coverage for Psychological Services

- Call the customer service number on the back of your insurance card.
- Ask to speak to a customer service representative instead of the automated benefits line, which often does not include Behavioral Health or Outpatient Mental Health benefits.
- State that you are seeking to verify your benefits for Mental Health or Behavioral Health with in-network and out-of-network providers.
- Ask if your Mental Health benefits are outsourced to another company, or through the company listed on your insurance card.
- If you already know the name of your provider and/or their practice, ask if they are in network or out of network for your insurance plan.
- If you are seeking group therapy, psychological testing, family therapy, inpatient care, or any other service besides individual outpatient therapy, go through all of these questions for each different type of service. Different benefits may apply to different types of psychological treatments.
- Ask the following questions to determine what your insurance will pay and what you will be expected to pay if you are utilizing insurance to pay for therapy.

Company your Mental Health benefits are through: _____

Most of the time this is the same as the company listed on your insurance card, but sometimes companies outsource Mental Health benefits. If this is the case, that means your provider/therapist would need to be in-network with the company your Mental Health benefits are through rather than the insurance company listed on your card!

Effective date of coverage: _____

Annual deductible: _____

Date deductible begins: _____

How much of the deductible has been met to date? _____

Does the deductible have to be met before Mental Health benefits apply? _____

Amount of co-pay per session: _____

Amount of co-insurance per session: _____

If you have both a co-pay and co-insurance, the combined total of the two amounts is what your amount per session will be after the deductible has been met (if a deductible applies).

If out-of-network, what is the allowable rate? _____

Does the allowable rate vary? _____

If so, what is the full range of allowable rates? _____

Maximum visits per year and/or lifetime: _____

Is telehealth covered? _____

Is my co-pay or co-insurance different if I am using telehealth? _____

Does a specific platform have to be used? _____

Do my benefits change if my therapist's business is in another state? _____

Your therapist should still be licensed in or legally allowed to practice in your state.

Do any other restrictions apply? _____

Maximum out-of-pocket amount per year: _____

Maximum out-of-pocket amount per lifetime: _____

Is referral from Primary Care Physician or Medical Group required? _____

This is usually only for an HMO plan. If such referral is required, only the member/client is authorized to obtain this referral and should follow through accordingly.

Where should in-network claims be submitted? _____

These are usually submitted by your provider/therapist.

If out-of-network, where should superbills be submitted? _____

These are given to you by your provider/therapist and submitted by you for partial reimbursement.

Is pre-certification or pre-authorization required? _____

If so, total amount of sessions authorized: _____

If so, authorization start date: _____

If so, authorization expiration date: _____