GRANT L. MARTIN, PH.D.

Licensed Psychologist #596 • 555 Dayton St., Suite C • Edmonds, WA 98020 • P: (425) 999-6285 • F: (425) 774-0690

INSURANCE BENEFIT INFORMATION

You need to call your insurance company in order to complete this form.

Mental and behavioral health benefits are different from traditional medical coverage. Your mental health benefits may be handled by a third party insurance company. The information is on the back of your card. It is your responsibility to call your insurance and complete the information below. Without the information, you may be required to pay in full at the time of service until obtained. Co-pays are due at the time of service.

Client Name _____ Relationship to Subscriber ☐Self ☐Spouse ☐Dependent

SUBSCRIBER INFORMATION

Name _____ Relationship to Client _____

Birthdate _____ / _____ / _____ Employer _____

Subscriber ID # _____ Group # _____

INSURANCE INFORMATION

Insurance Co. _____ Phone _____

Claim's Mailing Address _____

Mental Health Insurance Co. _____ Phone _____

Claim's Mailing Address _____

1) Ask your plan if the counselor you are seeing is in-network or out-of-network.

Mental Health Coverage	**Yes or No**
In-Network	
Out-of-Network	
If Out-of-Network, do you have benefits?	

2) Please complete the following benefits table. Each insurance plan varies as to whether or not your deductible needs to be met before they will pay your provider. Co-pay is due at the time of service.

Payment/Coverage	**Amount**	**Applicable Yes or No**
Co-pay	$	
Deductible	$	
Out-of-Pocket Max	$	
Reimbursement %	%	

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INSURANCE BENEFIT INFORMATION (continued)

Client Name _____

3) You will need to ask if each of the following codes is covered under your plan and if authorization is needed:

CPI Code	Description	Yes	No	Authorization #
90791	Intake			
90833-90834	Routine Sessions			
90837	45-60 min session			
90847	Family / Marriage Counseling			
96136 - 96137 96130 - 96133	Psychological Testing or Neuropsychological Testing			

REFERRAL

4) Does your insurance require you to get a referral from your PCP provider? ☐Yes ☐No

5) Do you have one if required? ☐Yes ☐No

AUTHORIZATION

6) Did any of the CPT codes require authorization? ☐Yes ☐No

7) If so, please obtain the authorization and indicate the following:

Authorization Number: _____ Authorization Date Range _____

Number of Visits Allowed: _____ CPT Code _____

I understand that services provided will be billed to my insurance company in a timely manner and that I will be sent a monthly statement regarding any balance due after my insurance has processed the claim(s). Your provider does accept debit and credit card in their office. Any questions or concerns I have will be addressed with the provider and/or his billing service (Revenue Concepts, 425-258-1880).

Client or Guarantor's Signature _____ Date _____ / _____ / _____

Printed Name_____