Anne Ethier Counseling
985 GAINES SCHOOL ROAD
BUILDING 2-E
ATHENS, GA 30605

INSURANCE VERIFICATION WORKSHEET

As a healthcare provider, my relationship is with you, not with your insurance company. Your insurance is a contract between you, your employer and the insurance company. I am willing to bill insurance on your behalf, but I need your help to bill correctly. This worksheet gives me complete and accurate insurance information. I greatly appreciate your help with this.

All clients must complete this worksheet prior to their first session. Bring it with you to your first session.

CLIENT INFORMATION:

Client Name: _____ Insured Person's Name: _____

Parent Name (if child is client): _____ Insured's Employer: _____

Client's Social Security Number: _____ - _____ - _____ Insured's Social Security Number: _____ - _____ - _____

Client's Date of Birth: _____ / _____ / _____ Insured's Date of Birth: _____ / _____ / _____

INSURANCE INFORMATION (can be found on your insurance card):

Insurance Company: _____ Plan/Group # : _____

Claims Address: _____ Insured's ID # : _____
(mental health claims) Street (may be SSN, Member #, or Policy #)

_____ Claims Phone # : (_____) _____
City State Zip (mental health claims – it may be different than other claims)

DETAILED BENEFITS INFORMATION (very important - please call your insurance company directly):

This section of the worksheet will help you better understand your current benefits and coverage and help me bill correctly.

⇢ *What telephone number did you dial?* **Phone #** : (_____) _____

⇢ *Who did you talk to?* **Contact Name**: _____ **Date/time of call**: _____

Say to the representative, *"I'm calling to clarify my coverage for outpatient mental health benefits."*
Ask enough questions to complete all the remaining information. Incomplete information will require additional phone calls.

⇢ *"Is my therapist, Anne Ethier, LPC , in-network for me"* ☐ YES ☐ NO

⇢ If NO, then ask "*Does my policy allow me to choose my own therapist*?" ☐ YES ☐ NO

* For Couples Only - *"Does my policy cover marital counseling?"* ☐ YES ☐ NO

Then ask about your insurance policy's:

⇢ **Effective date of policy?** ____/____/____ **Is your plan a(n):** ☐ HMO ☐ PPO ☐ EPO ☐ Other: _____

⇢ **Copay?** _____ % or $ _____ / session. Whichever is less.

⇢ **Deductible?** ☐ NO ☐ YES - Amount of Deductible: $ _____ / family OR individual?

Deductible per calendar year? ☐ NO ☐ YES - Month deductible begins: _____

Has any deductible been met for this year? ☐ NO ☐ YES - how much? $ _____

⇢ **Is pre-authorization needed?** ☐ NO ☐ YES – pre-authorization # : _____

⇢ **Any benefits used to date?** ☐ NO ☐ YES – describe: _____

⇢ **# of mental health visits allowed per calendar year?** _____ **# allowed per 24 consecutive months**? _____
beginning which month? _____

⇢ **How many mental health visits remain for this year**? _____

Failure to complete this form will result in you being charged the full-fee at time of service for first session