QUESTIONS TO ASK YOUR INSURANCE COMPANY REGARDING COVERAGE:

1) Do I have mental health benefits in my plan?

2) Do I have a deductible? If so, how much is it?

    a. Is it combined with my medical deductible in order to meet it?
    b. How much of it have I met so far?

3) What is the percentage that my insurance pays?

    a. For in-network providers:
    b. For out-of-network providers:
        i. Must my out-of-network provider register with you or be contracted with you in order for me to receive out-of-network benefits?

4) What is the percentage (or amount) that is my copay for psychotherapy sessions?

5) Is there a cap on the number of office visits that are allowed per calendar year?

6) Will my policy reimburse claims submitted under the "90834" CPT code? (Refers to a 45-minute individual psychotherapy session with face-to-face time lasting 38-52 minutes)

7) Will my policy reimburse claims submitted under the "90837" CPT code? (Refers to a 60-minute individual psychotherapy session with face-to-face time lasting 53 minutes or longer). Is pre-authorization required to use this code? If yes, what is the procedure for pre-authorization?

8) Will my policy reimburse claims submitted under the "90847" CPT code? (Refers to a 50-minute couple or family session)

9) Does my policy cover group therapy for mental health issues?

10) Do I need to be pre-certified or pre-authorized (per a phone call before being seen by a counselor)?

    If so, how many visits are allowed before I have to call again?

11) What is the effective date of my policy?

12) What is the specifier for "telehealth" sessions?

13) Where do I, as the patient, find the correct form to file an <u>out-of-network</u> claim?