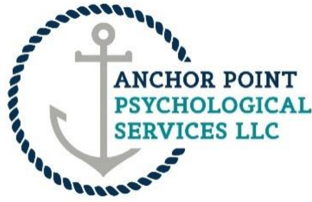

Out-of-Network Reimbursement Checklist

Many insurance companies allow for out-of-network reimbursement for a portion of the fees paid for outpatient mental health. Please contact member services for your insurance carrier to help verify the benefits available. This can help to estimate how much you should be reimbursed. Additionally, any amount spent towards out-of-network services may also apply towards your annual deductible.

If out-of-network benefits are available, you should ask the following questions:

1. How do I submit claims?

   ☐ Online: ____

   ☐ Fax: ____

   ☐ Mail: ____

2. Do I have a deductible? ☐ Yes ☐ No
3. How much is the deductible? ________________
4. What is the maximum number of visits per year? _____________
5. What percent of reimbursement is covered under my plan? ________________
6. What is the out-of-network reimbursement rate for the following procedure codes:

   90791 (*Diagnostic Evaluation without Medical Services*): _____________

   90834 (*Individual 45 minute psychotherapy*): ___________

   90837 ((*Individual 60 minute psychotherapy*): ___________

   90846 (*Family Therapy, without patient present*): ________

   90847 (*Family Therapy*): __________

7. Is authorization required? ☐ Yes ☐ No
8. If yes, how do I obtain authorization? ____

   ____

Effective Date: ____________ Expiration Date: ___________ Number of Visits: ____

Procedure Code(s) approved: ____

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