

Insurance Benefits For Outpatient Mental Health

Please fill out form completely. If any information does not apply, please mark with N/A. This information is required in order to bill your insurance for your therapy sessions with Dr. Cynthia Woelfel. If you do not have this information, please call the member services number on your insurance card to obtain your benefits for out-patient mental health. **Some insurance carriers utilize a carve-out carrier for mental health benefits; if that is the case with your carrier, please note that on this form.*

Patient's Name: _____ Date of Birth: _____ Patient's Gender: _____

Marital Status: _____ Telephone home: _____ Cell: _____ Work: _____

Address: _____ City: _____ State: _____ Zip: _____

Subscriber's Name: _____ Subscriber's Social Security #: _____

Subscriber's Member ID: _____ Group #: _____ Subscriber's Date of Birth: _____

If patient is a minor, name of person financially responsible: _____ Relationship to Patient: _____

*Mental Health and Substance Abuse Carrier Name (may be different from insurance carrier): _____

*Telephone Number of Mental Health Carrier: _____ Policy Effective Date: _____

Amount of Deductible: _____ Percent Payable by Insurance: _____ Copay Amount: _____

Maximum Number of Visits Allowed per Year: _____ Maximum Payable per Year: _____

Out-of-pocket Maximum: _____ Lifetime Maximum: _____ Authorization Required? Yes ☐ No ☐

Authorization Number: _____ Effective Dates of Authorization- From: _____ to: _____

Number of Sessions Authorized: _____ Is this authorization through you EAP? Yes ☐ No ☐

We will bill your insurance as a courtesy to you. If authorization is required prior to seeing a therapist, please call your mental health carrier to obtain authorization before making an appointment with Dr. Woelfel. If services are denied for no authorization, you are financially responsible for your therapy services.

I authorize Dr. Cynthia Woelfel to furnish the information necessary to file a claim with my insurance company. I authorize and assign direct payment of medical benefits under my insurance policy to Dr. Cynthia Woelfel. I agree to pay the amount owed in full if my insurance company does not pay.

Please sign below if you have read this form and agree to its terms and conditions

Signature _____ Date: _____

(For office use only) Dx code(s) _____, _____, _____, _____,