

PATIENT LAST NAME: _____ ACCOUNT # _____ ENTERED IN SCHEDULER _____

INTAKE CALL/BENEFIT VERIFICATION WORKSHEET

Appointment with: _____ Date of Appt: _____ Time: _____
Office Location: Schaumburg Vernon Hills Crystal Lake

Patient Name: _____ Patient SS#: _____ - _____ - _____

Patient's Date of Birth: _____ - _____ - _____ Age: _____

*For patients 18 - 25, is patient a student? **Yes/No** In College: **Yes/No**

*For patients 62 and over – If Medicare, is it managed by an Insurance co? N / Y If yes we can not take!

Home Phone: (_____) _____ - _____ Cell Number (_____) _____ - _____

Work: (_____) _____ Ext. _____ Other: (_____) _____ - _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Caller Name: _____ Caller Phone Number: (_____) _____ - _____

Relationship to the patient: spouse –parent-guardian-other _____

Can we leave a message at any of these numbers? Home Work Cell

Where would you like us to contact you regarding benefits? Home/Work/Cell No call needed

Clinical Info/Reason for Seeking Treatment: _____

Referral information: Please be specific (i.e. Dr. Brown, BC/BS, Fremd High School, etc.)

Insured/Policy Holder First and last Name: _____

Insured's Relation to Pt: self spouse parent step parent other: _____

Insured/Policy Holder SS #: _____ - _____ - _____ **Insured Date of Birth:** ____/____/____

Insurance Name(s): _____ PPO HMO POS

Insured ID Number: _____ **Patient ID Number:** _____

Group/Policy Number: _____

Place of Employment of the Insured: _____

Insurance Verification Phone Number:(_____) _____ - _____ (_____) _____ - _____

Precertification Phone Number: (_____) _____ - _____ (_____) _____ - _____

NOTES/COMMENTS/SPECIAL INSTRUCTIONS:

Confirmation of benefits explained to patient and copay/financial explanations due prior to appt on requested phone:

Benefits Specialist Initials _____ Date of call ____ - ____ - ____ Time: ____ Contact Type: LM/TTRP

Comments:

Packet sent for Woods/Raden/Lee-Samuel? Y/N **Will download from Website Y/N**

Intake Done by: _____ **Date:** _____ **Time:** _____

PATIENT LAST NAME: _____ ACCOUNT # _____ ENTERED IN SCHEDULER _____

BENEFIT INFORMATION

Ins. Co Reprs Name: _____ Correct Number: (_____) _____ - _____
Plan Effective Date: ____/____/____ Pre-Existing Conditions: Y/N until ____-____-____
Calendar Year: **Jan to Dec** - or -

IN NETWORK BENEFITS (PRA contracted rate)

Coverage %: _____ Copay: \$ _____ Max pd per session: \$ _____
90862 same? YES/NO If no, **90862 copay: \$ _____ Ded: _____ CYM: _____**
Deductible: Individual \$ _____ Family \$ _____ **Deductible met? YES/NO/UNK**
If no, deductible met to date: Individual \$ _____ Family \$ _____
Calendar Year Max: \$ _____ Days/Sessions: _____ Lifetime Max: \$ _____
Precert Required: YES/NO/Yes, Therapy Only Out of Pocket Limits: Individ _____ Family _____

Notes: _____

OUT OF NETWORK BENEFITS (fee for service rates) OR For BCBS, Serious Mental Illness Benefits

Coverage %: _____ Copay: \$ _____ Max pd per session: \$ _____
90862 same? YES/NO If no, **90862 copay: \$ _____ DED: _____ CYM: _____**
Deductible: Individual \$ _____ Family \$ _____ **Deductible met? YES/NO/UNK**
If no, deductible met to date: Individual \$ _____ Family \$ _____
Calendar Year Max: \$ _____ Days/Sessions: _____ Lifetime Max: \$ _____
Precert Required: YES/NO/Yes, Therapy Only Out of Pocket Limits: Individ _____ Family _____

Notes: _____

Claims _____
Mailing _____
Address _____

Benefits Verified by: _____ **Date Verified:** _____

MANAGED CARE INFORMATION PROVIDER AUTHORIZED: _____

Managed Care Company (*who you must be in network with*): _____
Person you spoke to: _____ Precert Number: (____) ____ - ____ ext: _____
Authorization #: _____ Precert Dates _____ to _____
EAP Auth: _____ Contact: _____ # sessions: _____ Dates: _____
Sessions Authd: 90801 _____ 90806/07 _____ 90862/05 _____ Other: _____
90805/90862 Interchangeable? Yes No **90806/90847 Interchangeable? Yes No**

Fees: 90801 _____	Copay: 90801 _____	SMI: 90801 _____
90847/05 _____	90847/05 _____	90847/05 _____
90806/07 _____	90806/07 _____	90806/07 _____
90862 _____	90862 _____	90862 _____

For In-network Benefits, Must be in Network with: _____ **In-Network clinicians:**

- | | | | | | |
|----------------------------------|-------------------------------------|-------------------------------------|-----------------------------------|---|-----------------------------------|
| <input type="checkbox"/> Perakis | <input type="checkbox"/> Lee-Samuel | <input type="checkbox"/> Crandall | <input type="checkbox"/> Green | <input type="checkbox"/> Lipin | <input type="checkbox"/> Spangler |
| <input type="checkbox"/> Resis | <input type="checkbox"/> Schoenbrod | <input type="checkbox"/> Cullen | <input type="checkbox"/> Hahnfeld | <input type="checkbox"/> Matusek | <input type="checkbox"/> Stern |
| <input type="checkbox"/> Woods | <input type="checkbox"/> McFaul | <input type="checkbox"/> Custer | <input type="checkbox"/> Jock | <input type="checkbox"/> Michaels | <input type="checkbox"/> Walz |
| <input type="checkbox"/> Kuo | <input type="checkbox"/> Altman | <input type="checkbox"/> Erlichman | <input type="checkbox"/> Kerley | <input type="checkbox"/> Perper-Davanzo | <input type="checkbox"/> Welch |
| <input type="checkbox"/> Paul | <input type="checkbox"/> Bondura | <input type="checkbox"/> Frankel | <input type="checkbox"/> Kukla | <input type="checkbox"/> Sabin | <input type="checkbox"/> Zercher |
| <input type="checkbox"/> Fabsik | <input type="checkbox"/> Borgman | <input type="checkbox"/> Gerard | <input type="checkbox"/> Lasco | <input type="checkbox"/> Smith | |
| <input type="checkbox"/> Raden | <input type="checkbox"/> Cooper | <input type="checkbox"/> G-Oberwise | | | |

Type of Clinicians Covered by benefits: MD/DO PsyD/PhD LCSW LCPC

Services Covered: Individual Family Group Psych Testing

THESE BENEFITS VERIFIED FOR: _____ **WHO IS** IN-NETWORK OUT OF NETWORK 9/11