

REQUEST FOR BENEFIT INFORMATION (COPY OF BENEFITS)

DATE OF REQUEST: ___-___-___ MD OR CLINICIAN THAT REFERRED PT TO YOU: _____

PATIENT NAME: _____ DOB: ___-___-___ ACCOUNT #: _____

IF PATIENT NAME IS DIFFERENT FROM PERSON'S RECORDS YOU WANT COPY – GIVE NAME OF PATIENT'S RECORDS YOU WANT COPIED: _____

APPOINTMENT WITH: _____ DATE OF APPOINTMENT: ___-___-___ TIME: _____

OFFICE LOCATION: SCHAUMBURG VERNON HILLS CRYSTAL LAKE

CURRENT INSURANCE INFORMATION SCRIPT – MUST DISCUSS BELOW QUESTIONS WITH PATIENT	
WHEN WERE YOU LAST SEEN AT PRA AND BY WHOM (IF MORE THAN 3 MONTHS, COMPLETE INTAKE VERIFICATION INSTEAD!)	DATE LAST SEEN: ___-___-___ NAME: _____
DO WE HAVE YOUR CURRENT INSURANCE CARD ON FILE?	YES NO IF NO, COMPLETE INTAKE VERIFICATION INSTEAD!
ALL INSURANCE MORE THAN 3 MONTHS OLD, MUST BE VERIFIED – COMPLETE INTAKE VERIFICATION INSTEAD!	

<input type="checkbox"/> FEES BASED ON CONTRACTED RATES (CLINICIAN IN-NETWORK) _____ INSURANCE
<input type="checkbox"/> FEE FOR SERVICE (CLINICIAN OUT OF NETWORK) _____ INSURANCE

CODES	FEES	COPAYS	SMI COPAYS
90801			
90804/05			
90806/07			
90847			
90862			

CLINICAL INFORMATION/REASON FOR SEEKING THERAPY: _____

MANAGED CARE/PRE-CERTIFICATION INFORMATION

PRE-CERTIFICATION NEEDED: YES NO

IF PRE-CERT IS NEEDED, WAS IT DONE? YES NO BY WHOM? THERAPIST PATIENT OFFICE STAFF

Managed Care Co.: _____
Person giving Auth: _____
Dept: _____
Precert contact #: ___-___-___
Auth/Conf#: _____
Auth range/dates: _____ to _____
90805/62 Interchangeable? <input type="checkbox"/> YES <input type="checkbox"/> NO

SERVICE CODE	NUMBER OF SESSIONS APPROVED
90801	
90805	
90806/07	
90847	
90862	
EAP SESSIONS	
OTHER:	

DATE PRE-CERTED: ___-___-___ TIME: _____ BY: _____

11/6/09

CLINICIAN NAME REQUESTING BENEFITS: _____ IS IN-NETWORK OUT OF NETWORK

TYPES OF CLINICIANS COVERED BY BENEFITS: MD/DO PsyD/PhD LCSW LCPC

COMMENTS: