



Billing Contact:  
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## MENTAL HEALTH/BEHAVIORAL HEALTH INSURANCE BENEFITS VERIFICATION FORM

Client's Name: \_\_\_\_\_

Client's Phone Number: \_\_\_\_\_ Client's Date of Birth: \_\_\_\_-\_\_\_\_-\_\_\_\_

Policy Holder's Name (if different from client): \_\_\_\_\_

Policy Holder's Date of Birth: \_\_\_\_-\_\_\_\_-\_\_\_\_

Primary Insurance/Behavioral Health Insurance Plan: *(Note: This may be different from your medical health insurance plan)*

Member ID #: \_\_\_\_\_ Group #: \_\_\_\_\_

Dependent's ID #: *(if child is the client, there should be a number listed after his/her name):* \_\_\_\_\_

Effective Date of Policy: \_\_\_\_-\_\_\_\_-\_\_\_\_

### **Questions for Your Insurance Provider:**

- 1) "Do I have mental/behavioral health coverage?"  YES  NO  
*(If YES, continue. If NO, there is no need to proceed; other payment arrangements must be made. Please contact therapist to discuss payment options.)*
- 2) "Is my preferred therapist in network?"  YES  NO  
*(If YES, go to In-Network Coverage, If NO go to question 3)*
- 3) "Do I have Out-of-Network benefits?"  YES  NO  
*(If YES, go to Out-of-Network benefits. If NO, there is no need to proceed; other payment arrangements must be made. Please contact the therapist with whom you want to work to discuss payments options.)*

### **In-Network Coverage**

- 4) "What is my co-pay amount?" \$ \_\_\_\_\_
- 5) "Do I have a deductible for outpatient behavioral health services?"  YES  NO
- 6) If YES, "What is my deductible?" \$ \_\_\_\_\_  
*(Now proceed to **Services Covered**)*

### **Out-of-Network Benefits**

- 7) "How much will I be reimbursed if I see an Out-of-Network therapist?" \$ \_\_\_\_\_
- 8) "Do I have an Out-of-Network deductible?"  YES  NO  
If YES, "What is my out-of-network deductible?" \$ \_\_\_\_\_

### **Services Covered**

- 9) "Can you please verify that the following services are covered under my policy?"  
•Individual Therapy  YES  NO    •Family Therapy  YES  NO    •Group Therapy  YES  NO

### **Services Authorized**

- 10) "Do I need an authorization to receive any of these services?"  YES  NO  
If YES, "What is my authorization number?" \_\_\_\_\_
- 11) "How many sessions are authorized?" \_\_\_\_\_