Sarah Horvath, LCSW

Required Insurance Form 2017

Call your insurance company and verify benefits. Please fill out prior to first appointment.

1.Name of primary insurance company:
____
Mental health customer service phone # ____
Policy ID # ____________________________________ Group # __________________________________
Name of patient & date of birth: ____
Name and date of birth of policy holder____

****MEDICARE POLICY HOLDERS – Skip to # 8, you don't have to answer questions 2 – 7 ******

2.Is Sarah Horvath, LCSW currently "IN-network" or "OUT - of network" for plan? In _____ Out _____
Are mental health benefits outsourced to a different insurance company? Yes ____No ____
If yes: Name: ________________________________ Phone # ______________________________________
If yes: Is Sarah Horvath, LCSW, IN or OUT of network provider for outsourced insurance company? In ___ Out ____

3. **"In-network"** benefits:
Is there a mental health deductible? Yes ___ No ___ Is the mental health and medical deductible combined? Yes ___ No ___
Deductible for individual____________________ Deductible for family________________
How much of the deductible has been met? Individual___________________________ Family______________________
What is the co-pay/co-insurance amount? ____
Is there a lifetime maximum for benefits? ____
Number of allowed visits per year____
What month does policy year begin? ____
Are couples or family therapy covered? Yes ___ No ___
Is psychological testing covered? Yes ___ No ___
Is prior authorization required? Yes ___ No ___ (If yes, see #5)

4. **"Out of network"** benefits: Are there any out of network benefits? Yes _______ No ________ (if no, skip to # 5)
Is there a mental health deductible? Yes ___ No ___ Is mental health and medical deductible combined? Yes ___ No ___
Deductible for individual____________________ Deductible for family________________
How much of the deductible has been met? Individual___________________________ Family______________________
What is the co-pay/co-insurance amount? ____
Is there a lifetime maximum for benefits? ____
Number of allowed visits per year____
What month does policy year begin? ____
Are couples or family therapy covered? Yes___ No ___
Is psychological testing covered? Yes ___ No ___
Is prior authorization required? Yes ___ No ___ (If yes, see #6)

5.Is an authorization required? Yes ______ (if yes, ask for authorization) No ______ (if no, skip to # 7)
Number and type of sessions authorized____
Authorization number: ____
Date authorization covers____

6. What is the claims billing address? ____
____

7. Is there a "Multi Plan" insignia on your insurance card? Sometimes on back of card. Yes ______ No ______

8. Is there a secondary insurance policy? Yes______ No ___________
If yes: Name_______________________________ Policy # _________________________ Group# __________________
Mental Health Customer service # ____

Fax (512-858-9001) information prior to first appointment or bring with you to first appointment.
Please provide copy of insurance cards, or we can make copies at our office for you.