GUIDELINES FOR CALLING TO FIND OUT IF YOUR HEALTH INSURANCE PLAN INCLUDES OUT-OF-NETWORK BENEFITS

Call the Member Services number on the back of your insurance card.

Explain you're about to begin mental health services with a provider who's not in network with your insurance plan.

Ask, does my plan include out-of-network benefits for outpatient behavioral health services? The representative may ask for the CPT codes that would be submitted for services. They are listed below:

Common CPT codes for mental health services we provide are:
90791: Diagnostic Clinical Evaluation (intake session)
90834 - 45-minute individual therapy session
90837 - 60-minute individual therapy session
90847 Family therapy with client present
90846 - Family therapy without the client present (includes parent-only sessions for minor clients)

If yes, your plan does include out-of-network benefits, ask do I need pre-authorization from a medical professional?

Do I have a deductible to meet before my out-of-network benefits take effect?

If yes, how much is my out-of-network deductible and how much of my out-of-network deductible is currently remaining?

Once I meet my deductible, what percent of the cost of services will I be reimbursed?

Is my reimbursement based on a percentage of the actual fee billed or of a particular maximum fee covered?

What is the process for submitting out-of-network claims (where can I locate the claims form, can I submit multiple dates of service at once, etc.?)

Record the representative's name and request a reference # for your benefits eligibility call. This information will be helpful if you ever need to dispute a rejected claim.