



## Insurance Fact-Check Worksheet

For checking your coverage for reimbursement for therapy services

Ins. Provider: \_\_\_\_\_ Member services #: \_\_\_\_\_

Call date: \_\_\_/\_\_\_/\_\_\_ Representative name: \_\_\_\_\_

- 1) **What is my insurance amount covered per each individual (CPT:90834) /couples (CPT:90837) session with an out-of-network behavioral health provider with a precicensed associate MFT registration?** (This will be a flat fee or a percentage of the total cost): \_\_\_\_\_
- 2) **What is my insurance plan deductible?** (if applicable): \$\_\_\_\_\_
- 3) **What is my per-session copayment (flat fee) or coinsurance (percent) amount?:** \_\_\_\_\_
- 4) **How many visits or sessions will be covered?** (if applicable): \_\_\_\_\_
- 5) **When does my insurance coverage start and renew?**  
Effective: \_\_\_/\_\_\_/\_\_\_ Renew: \_\_\_/\_\_\_/\_\_\_
- 6) **How much of my deductible have I met so far this year?** (if applicable): \$\_\_\_\_\_
- 7) **Does my plan cover behavioral health visits offered via telehealth?** Y / N
- 8) **What is the process for submitting a reimbursement claim?**

This worksheet is provided as an informational tool and does not guarantee insurance reimbursement.

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