FOR CLIENTS:
CHECKING YOUR COVERAGE TO SEE AN OUT-OF-NETWORK THERAPIST

BEFORE CALLING INSURANCE: INFO TO GET (SOME IS ON YOUR INSURANCE CARD)

1. Insurance I.D. #: _____ Group #: _____
2. Primary Subscriber on the Insurance:_____
3. Your Relationship to Primary Subscriber: _____
4. Primary Subscriber's Birthdate: _____ /_____ /_____ Your Birthdate: _____ /_____ /_____
5. Subscriber's Employer_____
6. Insurance Plan Phone Number (*i.e "Member Services," "Behavioral Health", "Mental Health Coverage," "Eligibility and Benefits," or simply "Customer Service"):* **_____**

THE CALL: WHAT TO ASK THE INSURANCE COMPANY

Note Your CALL DATE: _____ /_____ /_____ REPRESENTATIVE Name_____

1. I am seeking outpatient mental health benefits in a professional office setting (or via telehealth). Does my plan cover out of network providers for this service? If so, what is the coverage? What is my coinsurance? (this is the percentage of the fee you will pay)	
2. For telehealth: Is the coverage temporary? If so, until when?	
3. What is my Out-of-Network deductible? (The deductible is the amount you must yourself before the plan begins paying at all). You may have a separate deductible for in-network providers and one for out-of-network providers.	
4. How much of the out-of-network deductible has been met so far this year?	
5. My therapist charges $_____. Is this within the Allowed Amount for an Out-of-Network Provider? If not, whatistheAllowedAmount? (Someplansmaycapthe amount they allow, and reimburse based on this, but may not disclose the Allowed Amount)	
6. Are there any limits to the number of sessions per year?	
8. When do benefits start and renew (you want to know when your deductible renews)? **Is my coverage active?**	**Effective: ____ /____ /____** **Renew: ____ /____ /_____**
9. How do I submit invoices to the plan for reimbursement? What is the address where I would send MENTAL HEALTH claims? (In our office, "Superbills" are provided through Simple Practice)	
10. What is the Out-of-pocket Maximum? (The amount you must pay each year before the plan starts paying 100% for health expenses)	
12. Can you give me a Call Reference Number for this call?	

Zimmerman Therapy Group
644 Pollasky Ave #203 Clovis, CA 93612 (559) 212-4377

ZIMMERMAN
THERAPY GROUP

From Zimmerman Therapy Group
644 Pollasky Ave #203
Clovis, CA 936121883

Statement for Insurance Reimbursement

To [redacted]

Client [redacted]

Insured Company Member

Statement 10872
Issue Date 08/23/2022

Provider Stephanie Zimmerman

(559) 212-4377
support@zimmermantherapygroup.com

NPI: #1659500353
License: LMFT #MFT51755

Practice Tax ID: 47-3905871
NPI: 1689297475

DX	Diagnosis Code
1	F33.1 - Major depressive disorder, recurrent, moderate

Procedure Code

Date	Service	DX	Description (Insurance Place of Service)	Fee	Paid
08/22/2022	90846	1	Family Psychotherapy without patient present (11)	$135	$135
08/22/2022	90837	1	Psychotherapy, 60 min (11)	$135	$135
08/23/2022	90837-95	1	Tele therapy, Psychotherapy, 60 min (02)	$135	$135

Service Code

Total Charges $405
Total Paid $405
Make payments to: [redacted]

This should always be the clients or clients parents name