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**MENTAL HEALTH/BEHAVIORAL HEALTH**

**INSURANCE BENEFITS VERIFICATION FORM**

Patient’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient’s Date of Birth: \_\_\_\_\_-\_\_\_\_-\_\_\_\_\_\_

Policy Holder’s Name (if different from patient):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy Holder’s Date of Birth: \_\_\_\_\_\_\_-\_\_\_\_\_\_-\_\_\_\_\_\_\_ Policy Holder’s Soc. Sec. #: \_\_\_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_\_\_\_

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 patient, there should be a number listed after his/her name):* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Effective Date of Policy: \_\_\_\_\_-\_\_\_\_-\_\_\_\_\_\_ Expiration 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.)*

1. “Is my preferred therapist ***\_\_\_\_\_Melanie Masters, LMFT\_\_\_\_*** in network?” □ YES □ NO

*(If* ***YES****, go to In‐Network Coverage, If* ***NO*** *go to question 3)*

1. “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**

1. “What is my co‐pay amount?” $\_\_\_\_\_\_\_\_\_\_
2. “Do I have a deductible?” □ YES □ NO
3. If **YES**, “What is my deductible?” $\_\_\_\_\_\_\_\_\_\_

*(Now proceed to* ***Services Covered****)*

**Out‐of‐Network Benefits**

1. “How much will I be reimbursed if I see an Out‐of‐Network therapist?” $\_\_\_\_\_\_\_\_\_\_
2. “Do I have an Out‐of‐Network deductible?” □ YES □ NO

If **YES**, “What is my out‐of‐network deductible?” $\_\_\_\_\_\_\_\_\_\_

**Services Covered**

1. “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**

1. “Do I need an authorization to receive any of these services?” □ YES □ NO

If **YES**, “What is my authorization number?” \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. “How many sessions are authorized?” \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_