

Lucy Heggenstaller M.S.W., L.C.S.W., B.C.D.
3 Hospital Drive, Suite 308
Lewisburg, PA 17837

MENTAL HEALTH INSURANCE INFORMATION

Please understand that **Mental Health (or Behavioral Health)** coverage is very different from **Medical** coverage. Usually Mental Health benefits have different deductibles, co-payments and may have a more limited number of covered visits.

To help you understand your Mental Health benefits, I ask that you contact your insurance company to clarify what is covered and what your responsibilities are. If you wish to use insurance coverage, you are required to complete this form. It is designed to help you understand your benefits and to assist my billing person in billing for your services promptly.

PRIMARY INSURANCE INFORMATION (If the client to be treated is covered by more than one policy, this would be the company that has first responsibility for payment, unless you have an EMPLOYEE ASSISTANCE PROGRAM.)

Name of Company: _____
Street address: _____
City/State/ZIP: _____
Telephone of Company: _____
Policy number: _____
Group number: _____
Name of the insured (Usually the person whose employee benefits you plan to use.) _____
Relationship of the patient to the insured:) _____
Birthday of the insured _____
SS# of the insured _____
Name and telephone number of your Mental Health/Behavioral Health company (if different from the name on the front of your card): _____

Please call the Mental Health company and ask:

Is Lucy Heggenstaller in-network? _____ Yes _____ No
If not, do I have out-of-network benefits? _____ Yes _____ No
Are LCSWs eligible providers? _____ Yes _____ No
Do I need authorization for services? _____ Yes _____ No
If so, list authorization number here: _____
Do I have a deductible? _____ Yes _____ No
If so, list amount here: _____
Do I have a co-payment? _____ Yes _____ No
If so, list amount of co-payment here: _____
Is there a limit on my coverage? _____ Yes _____ No

If so, describe: _____

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SECONDARY INSURANCE INFORMATION (If the client to be treated is covered by more than one policy, this would be the company that is billed after the PRIMARY INSURANCE has paid their portion.)

Name of Company: _____

Street address: _____

City/State/ZIP: _____

Telephone of Company: _____

Policy number: _____

Group number: _____

Name of the insured (Usually the person whose employee benefits you plan to use.) _____

Relationship of the patient to the insured: _____

Birthday of the insured _____

SS# of the insured _____

Name and telephone number of your Mental Health/Behavioral Health company (if different from the name on the front of your card):

Please call the Mental Health company and ask:

Is Lucy Heggenstaller in-network? _____ Yes _____ No

If not, do I have out-of-network benefits? _____ Yes _____ No

Are LCSWs eligible providers? _____ Yes _____ No

Do I need authorization for services? _____ Yes _____ No

If so, list authorization number here: _____

Do I have a deductible? _____ Yes _____ No

If so, list amount here: _____

Do I have a co-payment? _____ Yes _____ No

If so, list amount of co-payment here: _____

Is there a limit on my coverage? _____ Yes _____ No

If so, describe: _____

GUARANTOR INFORMATION (This is the person who is responsible for payment of fees not paid by the insurance company or companies above.)

First name: _____ MI _____ Last name: _____

Address: _____

City/State/ZIP: _____

Phone numbers: H _____ W _____ C _____

If fees are to be split according to a custody agreement, please attach a copy of the agreement.

AUTHORIZATION FOR INSURANCE BILLING

I authorize Lucy Heggenstaller, M.S.W., L.C.S.W., B.C.D., to apply for benefits on my behalf for her services to myself or my minor child. I request that my insurance company pay Lucy Heggenstaller directly. I certify that the information that I have provided regarding my insurance coverage or the insurance coverage on my child is correct.

I authorize the release of any necessary information, including medical and mental health information for the payment of my mental health claims or the mental health claims of my child. I permit a copy of this authorization to be used in the place of the original. This authorization may be revoked by me at anytime in writing. I understand that nothing herein relieves me of the primary responsibility and obligation to pay for the mental health services provided by Lucy Heggenstaller, should my insurance company deny payment, when a billing statement is rendered to me.

Should I be billed for these services because my or my child’s mental health claims were denied, or billed for a portion of these services to cover out-of-pocket liabilities such as co-payments and deductibles, I agree that it is my responsibility to pay for these charges on a timely basis, but in no case later than 30 days from the billing date, unless prior arrangements have been made. If my account, or the account for my minor child, becomes delinquent I agree to pay for costs related to the collection of these fees. I also have read and agree to Lucy Heggenstaller’s FINANCIAL POLICIES.

Primary Policy Subscriber signature/Guarantor **Date**

Secondary Policy Subscriber signature/Guarantor **Date**

(Complete if there is more than one responsible party or more than one mental health insurance.)

WHEN YOU COME TO YOUR APPOINTMENT, PLEASE HAVE YOUR INSURANCE CARDS READY TO BE COPIED FOR OUR RECORDS.

THANK YOU FOR YOUR COOPERATION!