Insurance Benefit Information

Counselor: **P. Roger Hillerstrom, M.A., L.M.H.C.**

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(425) 774-4673 **FAX: (425) 774-0690**

Client's Name: _____

Client's Relationship to Subscriber: ☐**Self** ☐**Spouse** ☐**Dependent**

Subscriber Information:

Date of birth: _____

Employer: _____

Insurance ID #: _____

Insurance Group #: _____

Insurance Information:

Insurance Company Name: _____

Insurance Company's Address: _____

Insurance Company's City, State, Zip: _____

Insurance Company's Contact Phone #: _____

Mental and behavioral health benefits are different than traditional medical or dental coverage. It is your responsibility to call your insurance company to find out the information requested below. Without this information, you will be billed for these services, and it will be your responsibility to submit your claim to your insurance company for reimbursement.

Mental Health Company's Name (often different): _____

Mailing Address for Mental Health Claims: _____

Contact Phone #: _____

Referral/Authorization required: □ Yes □ No Authorization #: _____

Number of sessions per year: _____

Co-pay Amount: _____

Deductible Amount per Individual: _____

Calendar or Fiscal year: _____

Anniversary Date: _____

Marriage/Family Counseling (Code 90847) Covered: □ Yes □ No

Psychological Testing (Code 96101) Covered: □Yes □ No

Preferred Provider: □ Yes □ No

Participating Provider: □ Yes □ No

Out of Network Benefits: □ Yes □ No