Catholic Charities of the Diocese of Lexington

Insurance Form

This form needs to be completed by the insured person or the insured person's authorized representative. Please call your insurance company **prior to the first session** to see if your visit needs to be pre-authorized and to learn what, if any, services/procedures are covered. Please ask for the information in the box below:

TO BE PROVIDED TO YOU BY THE INSURANCE COMPANY WHEN YOU CALL:

Authorization Number:____
Effective Start Date:_____________________ **Effective End Date:**____________________
Number of Visits Authorized: ______________________
Deductible:______________________ **Visit Co-payment:**___________________________

Procedure (CPT) codes allowed for non-physician services (please circle all that apply):
90791, 90785, 90832, 90834, 90837, 90839, 90840, 90846, 90847, 90849, 90853, 90889, 99354, 99355, 99366, 99368

The following information is needed to create an insurance claim. Please fill in **all** spaces.
Name of Counseling Client____
Patient Relationship to Insured (Circle) Self Spouse Child Other

Insured's ID Number:____
Insured's Name: Last Name___________________ **First Name**____________ **MI**___
Insured's Date of Birth: ____
Insured's Address: Line 1____
Line 2____
City_________________________________ **State**_______ **Zip**_______
Insured's Phone Number (include area code)_______________________________________
Name of Insurance ____
Is this the only insurance company? Y or N Is this the PRIMARY insurance? Y or N
Plan or Program Name:____

I authorize payment of medical benefits to Catholic Charities of the Diocese of Lexington for mental health services.

____ _______________________
Insured or Authorized Person's Signature **Date**

If you have insurance coverage from more than one insurance company, please fill out a form for each company.

PLEASE ATTACH A COPY OF THE INSURANCE CARD, FRONT AND BACK.

Last updated October, 2016