Client Insurance Checklist

Client Full Name _____ Today's Date _____
FIRST MI LAST

SS#/SIN _____ Age _____ Date of Birth _____ Clinician _____

POLICY HOLDER INFORMATION:

Full Name _____ ☐ Male ☐ Female
FIRST MI LAST

SS#/SIN _____ Age _____ Date of Birth _____ Relationship to Client _____

_____
STREET/APT CITY STATE ZIP CODE

INSURANCE INFORMATION:

Insurance Company _____ Member ID# _____

Group #_____ Provider Services Phone # (Located on back side of card) _____

We recognize that understanding your insurance and mental health coverage can be overwhelming. With this checklist in front of you, please call the toll-free member services number on the back of your insurance ID card to complete this form.

1. What is your co-payment for outpatient mental health services (per session)? _____

2. Do you have a deductible? NO YES

   If yes, what is the deductible amount? _____ How much of that has been met? _____

3. Do you need a referral from your primary care physician? NO YES

   If Yes, What is the name of your Primary Care Physician? _____ Phone Number _____.

   Did you ask them to send your insurance provider a referral? NO YES, they sent it on _____.

4. Does your plan require pre-authorization? NO YES

5. Does your employer offer EAP services? NO YES
   If yes, what is the authorization number? _____. How many sessions are you approved for? _____.

   What are the start and end dates of authorization _____.

All of this information must be supplied in order to submit claims to your insurance carrier. If you do not obtain this information or do not provide Compass Point with the correct information, any unpaid balance will be your responcibility. Also, it is important to notify Compass Point of any insurance or benefit changes throughout the course of treatment. Any insurance changes will require all information to be updated.

X_____
Signature of client (or responsible party if minor)