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OUT-OF-NETWORK INSURANCE VERIFICATION

Please use this form to learn about your out-of-network benefits.

Patient Name: _____ Date: _____

Name of my Insurance Company: _____

I am an out-of-network provider. If your insurance plan provides out-of-network benefits, you may be able to receive partial reimbursement from your insurance company for the fees you pay me for your treatment. To learn more about this, contact your insurance to obtain answers to the following questions:

(1) Telephone number to call to check my benefits & eligibility: _____

(2) Does my insurance plan cover "out-of-network outpatient mental health services?" Y / N

If **yes**, continue with the rest of this form. If **no**, your insurance will **NOT** reimburse you for our visits.

(3) Is my health insurance coverage active? Y / N (a) If yes, my policy became effective on: _____

(4) Are my mental health benefits based on a calendar year? Y / N

(a) If no, my benefits are based on this range of dates: _____

(5) Do my mental health benefits depend on whether I have a "parity diagnosis" or not? Y / N

(6) How many mental health visits are covered each year? _____

(a) How many remaining visits to do I have this year? _____

(7) Do I have to get an authorization for coverage of my therapy sessions? Y / N

(a) If yes, who must call to obtain the authorization? _____

(b) The telephone number to call to obtain the authorization is: _____

Regarding partial insurance reimbursement for psychotherapy appointments:

(8) Do I have a deductible (\$ that I must pay out of pocket before insurance begins to pay)? Y / N

(a) If yes, my deductible for out-of-network appointments is: _____

(9) My psychiatry appointments cost \$260. What is the "allowed amount" (the upper limit amount that your insurance plan considers the appointment is worth) for visits coded under CPT codes:

99213 + 90836? _____ vs. 99213 + 90838? _____ vs. 90837 _____

(10) What percentage of each office visit does my insurance plan cover for out-of-network outpatient mental health visits? _____

(11) The net amount I would have to pay out-of-pocket after insurance reimburses me for each session would then be: \$260 - ("allowed amount" x "percentage covered by insurance") = _____

(12) What is my annual maximum out-of-pocket limit for out-of-network outpatient mental health services? _____

(13) How do I submit insurance claims: by mail / electronically.

(a) What is the mailing address / website I should use? _____

Feel free to bring this completed form with you to your appointment if you'd like to review it with me.