# Information Checklist for Insurance Coverage for Mental Health Benefits

Most people choose to use their health insurance coverage to pay for all or part of the cost for mental health counseling. If you are considering this payment option, you need to contact your insurance provider directly to understand your coverage. The contact information is usually located on the back of your insurance card. Make sure you note the number you called, the date and time of the call as well as the person providing the information about your coverage and information related to the categories listed below. If the information does not match what you think your insurance coverage should be, call again and double check. After you receive services, make sure you check your Explanation of Benefits (EOB) to make sure your coverage has been calculated correctly.

Feel free to contact my office if you have any questions.

Wishing you the best,

Dorothy Rado, LCSW, LMFT, ACSW
Tides of Life
317-398-8361

Some of the topics we suggest you ask your insurance company about include:

1. **Coverage for Mental Health Counseling**-first make sure your plan has coverage for outpatient mental health counseling. If they say you do not have coverage, call your employer to double check.

2. **In-network vs. Out of Network Benefits**-Most insurance products have a list (network) of preferred providers. Usually benefits are better if you receive care from a provider on this list. Check to see if Dorothy Rado, LCSW is listed in your network. If not call our office and we will try to add her to that insurance network.

3. **Deductible**-Some plans have a set amount of money you must pay (deductible) before insurance begins to cover some of the costs of your care. Some plans have a separate deductible for different types of care such as medical, mental health, pharmacy, dental and labs. Be sure to ask how your mental health deductible is calculated and how much of your deductible has been met.

4. **Coverage/Copay**-Insurance plans have different ways of determining how much you will owe for your care. Typically, you must first meet your deductible, and then they will cover a percentage of the "contractual" amount. The "contractual" amount is the fee the insurance company determines in an appropriate amount for the service provided. The provider typically agrees to this fee. You would then be responsible for a percentage of this contractual fee. In the case of copay, you are responsible for a fixed amount of money per visit.

5. **Numbers of Visits-**Some plans **limit** the number of visits they will cover in a certain time frame. Such as 15 visits per calendar year.

6. **Amount of Coverage—**Some plans limit the amount of coverage in a certain time frame, such as **$100,000 per lifetime or** "coverage up to $25 per visit"

7. **Provider Type**-Some plans will only cover a certain type of provider or location of service. Such as plans covering only a psychologist or a hospital based service.

8. **Referral or Precertification**-some plans require a referral from an outside source such as a doctor or EAP, others accept self-referrals. Additionally, some plans will only authorize coverage for a certain number of visits or certain types of visit.

9. **Limits of Coverage**- Most plans only cover mental health services that meet the criteria of "medically necessary" care. Services such as marital counseling, parenting, behavior problems, academic problems may not be considered medically necessary and therefore may not be covered by your insurance

10. **Other**-Always ask if your plan has any other limitations or rules that you need to be aware of. Sometimes you will discover an unexpected stipulation in coverage such as 2 members of the same family can't be seen by the same provider.

11. **Call our office if you need help.** Insurance coverage is complex and confusing. We will try to help you navigate **the maze; just give us a call at 317-398-8361.**

Sincerely,

Dorothy Rado, LCSW, LMFT, ACSW

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