

Center for Brain Insurance Info Sheet

This document describes questions you should ask your insurance company when considering making a claim for reimbursement. We are unable to file your insurance for you but will give you a completed claim form for you to submit. Some companies may take up to three months to reimburse.

Please share the information you receive from your insurance company with us so we can help you.

Note that once you have submitted a claim, Center for Brain may not hear from them, so you will need to periodically check on its status.

1. Do you have out-of-network benefits? Yes ___ No ___

If no, insurance reimbursement is not possible because our center is an out-of-network provider. If yes, please continue.

2. Does your policy cover mental health? Yes ___ No ___

If yes, continue to #3. If no, reimbursement is not possible, with the following exceptions: sleep disorder/ blood pressure issues/ migraines/ chronic pain /fibromyalgia/seizures/chronic fatigue syndrome/stroke or aneurism or other brain rehab issues. If so, ask the agent if your policy covers code 96152. If not, reimbursement is not possible. If yes, continue to #3.

3. Does your policy reimburse for the services of a licensed mental health counselor (LMHC)? Yes ___ No ___

If yes, please continue. If no, reimbursement is not possible.

4. Do you have out-of-network coverage? Yes ___ No ___

If no, reimbursement is not possible.

If yes, how much is your out-of-network deductible? \$ _____

4a. Is your mental health deductible separate from your regular health benefits? Yes ___ No ___

If separate, how much is your mental health out-of-network deductible? \$ _____

How much of your out-of-network deductible have you met this year? \$ _____

When is the end of your insurance policy's fiscal year? _____

5. Does your insurance company reimburse the providers of out-of-network services directly or do they reimburse the policyholder? Reimburses providers ___ Reimburses policyholder ___

6. Limits of your out-of-network mental health services:

Are you limited to a specific number of visits per year or a specified monetary amount?

Specific number of visits ___ Specified monetary amount \$ _____

If yes, explain here: _____

6b. If additional sessions are necessary, can they be obtained by the provider stating your need for additional treatment or do you have a maximum allowed?

Additional treatment allowed ___ Maximum treatment allowed ___

7. Do you need authorization for treatment? Yes ___ No ___

If yes, what is the authorization number? _____

How many visits is the authorization for? _____

8. Who reauthorizes your treatment, the provider or the policyholder? _____

9. Will your insurance company reimburse for codes 90901, 90832, 90834, 90901 or 90876? (note: Center for Brain may only be able to bill for 90901. This information is for your clarification only.)

9a. Is there any type of documentation necessary for either code prior to treatment? Yes ___ No ___
If yes, what is needed and where is the information sent? _____

10. How much will your insurance company pay for the following procedures:

90901 \$ _____ or _____ %
90876 \$ _____ or _____ %
90834 \$ _____ or _____ %
90832 \$ _____ or _____ %

Your insurance company may provide you with an amount or a percentage. This is asked in order to assist you in determining your financial responsibility for treatment, so please try to get an actual amount. 90901 is the best true biofeedback code. If they won't pay for any of the codes, then it will be out of pocket for the client)

11. If an MD requests a qEEG for the client/patient, which codes and how much will be covered?

95816 \$ _____ 95957 \$ _____ 95818 \$ _____

12. Name of the person you spoke with: _____

13. Date of the conversation _____

14. Time of the conversation _____

Signature of this form is necessary to have us file for reimbursement with your insurance carrier. It also indicates that: 1) you have obtained the required information and that 2) you understand that filing for reimbursement is not a guarantee that the insurance company will reimburse. You understand you are responsible for either partial payment (when insurance reimburses) or full payment for your treatment if your insurance carrier will not reimburse. Additionally, insurance companies that do not reimburse out-of-network providers directly but do reimburse the policyholder are required to pay at the time of service and seek reimbursement. Your signature also gives Center for Brain permission to share required information with your insurance company in order to receive reimbursement.

Client's name: _____

Signature of Authorizing Party who is financially responsible:

Name (in print) _____

Address _____

City, State, Zip _____

Date signed: _____

The last thing needed for us to help you file a claim is a diagnosis code. This is from the primary doctor of the patient for the condition being treated. **Make sure that the insurance will pay for the procedure codes for that diagnosis! The code will look like 299.03 or 314.01. Insurance will not pay without a diagnostic code.**



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