

INFORMATION TO ASSIST WITH
PRE-AUTHORIZATION AND RETROSPECTIVE CLAIMS

The following is a list of some information that you should have available that may assist you with getting pre-authorization for services, claim payment for services, or appealing a claim denial.

Member Name

Member Insurance ID number

Patient Name and Date of Birth

Patient Relationship to You

- Guardianship paperwork
- Adult Patient - Authorization to Represent

Is the patient a threat to himself / herself or others?

Insurance Company Name

Insurance Company Phone Number

Insurance Plan Name or ID Number

Insurance Plan type:

- Individual Plan
- Group Plan
- Employer Benefit Plan
- Plan includes Out-of-Network Benefit for requested services
 - Limits on benefit, if any (such as a penalty or reduced payment for Out-of-Network services)
- Plan does not include Out-of-Network Benefit for requested services

Treating Provider Name and Contact Information

- Treating Provider is In-Network
- Treating Provider is Out-of-Network

Primary Care Doctor Name and Contact Information (if different than Treating Provider)

Provider Referral Letter (if required)
Provider Letter of Medical Necessity for Requested Services

Other Providers Involved in Treatment

Type of Services Requested:

- Mental Health
- Substance Use Disorder
- Electro Convulsive Therapy (ECT)
- Repetitive Transcranial Stimulation (rTMS)
- Applied Behavior Analysis (ABA)
- Psychological Testing
- BioFeedback
- Skilled Nursing
- Traumatic Brain Injury Rehabilitation
- Habilitative Services
 - Physical Therapy
 - Occupational Therapy
 - Speech Therapy
- Medication
- Medical Supplies, Equipment or Device
- Other _____

Location of Requested Services:

- Treating Provider's Office
- Home or School
- Outpatient
- Intensive Outpatient Program
- Partial Hospitalization Program
- Acute Inpatient
- Inpatient Rehab
- Acute Inpatient Detox
- Residential
- Skilled Nursing Facility
- Telehealth

Has the patient been treated for this before? If yes:

- Dates of previous treatment(s)
- Provider(s) of previous treatment(s)
- Location of previous treatment(s)

Patient Share of Costs for Requested Services

- Co-payment amount
- Unmet Deductible
- Co-insurance amount or percentage
- Annual Out-of-Pocket Maximum