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