



BANYAN TREE
COUNSELING

Chantal D. Hayes, M.A., LPCA, NCC, CLC
Licensed Professional Counselor Assoc. #A9282
1348 Westgate Center Dr. Suite 203
Winston Salem, NC 27103
Phone/Fax: (336) 448-4451
chantalhayesLPC@gmail.com

MENTAL HEALTH/BEHAVIORAL HEALTH INSURANCE BENEFITS VERIFICATION FORM

Patient's Name: _____

Patient's Date of Birth: ____-____-____

Policy Holder's Name (if different from patient): _____

Policy Holder's Date of Birth: ____-____-____ Policy Holder's Soc. Sec. #: ____-____-____

Primary Insurance/Behavioral Health Insurance Plan: *(Note: This may be different from your medical health insurance plan)*

Member ID #: _____ Group #: _____

Dependent's ID #: *(if child is the patient, there should be a number listed after his/her name):* _____

Effective Date of Policy: ____-____-____ Expiration Date of Policy: ____-____-____

Questions for Your Insurance Provider:

- 1) "Do I have mental/behavioral health coverage?" YES NO
(If YES, continue. If NO, there is no need to proceed; other payment arrangements must be made. Please contact therapist to discuss payment options.)
- 2) "Is my preferred therapist Chantal Hayes, MA, LPCA in network?" YES NO
(If YES, go to In-Network Coverage, If NO go to question 3)
- 3) "Do I have Out-of-Network benefits?" YES NO
(If YES, go to Out-of-Network benefits. If NO, there is no need to proceed; other payment arrangements must be made. Please contact the therapist with whom you want to work to discuss payments options.)

In-Network Coverage

- 4) "What is my co-pay amount?" \$ _____
- 5) "Do I have a deductible?" YES NO
- 6) If YES, "What is my deductible?" \$ _____
*(Now proceed to **Services Covered**)*

Out-of-Network Benefits

- 7) "How much will I be reimbursed if I see an Out-of-Network therapist?" \$ _____
- 8) "Do I have an Out-of-Network deductible?" YES NO
If YES, "What is my out-of-network deductible?" \$ _____

Services Covered

- 9) "Can you please verify that the following services are covered under my policy?"
•Individual Therapy YES NO •Family Therapy YES NO •Group Therapy YES NO

Services Authorized

- 10) "Do I need an authorization to receive any of these services?" YES NO
If YES, "What is my authorization number?" _____
- 11) "How many sessions are authorized?" _____