

### **STEPS TO VERIFY YOUR "OUT OF NETWORK" BENEFITS WITH RITA PRELLER, LCSW-C**

CALL YOUR INSURANCE COMPANY TO VERIFY YOU ARE ELIGIBLE FOR "OUT OF NETWORK" BENEFITS WITH RITA PRELLER, LCSW-C.

IF SO, CHECK TO SEE IF AN AUTHORIZATION IS NEEDED FOR INDIVIDUAL, FAMILY, AND GROUP VISITS. SHOULD AN AUTHORIZATION BE NECESSARY, PLEASE OBTAIN INFORMATION ON WHERE AND TO WHOM THE OUTPATIENT TREATMENT PLAN NEEDS TO BE SENT. ALSO, PLEASE PROVIDE A FAX NUMBER TO RITA PRELLER, LCSW-C.

BE SURE TO KEEP TRACK OF ALL AUTHORIZED VISITS. WHEN YOU ARE NEAR THE END OF YOUR AUTHORIZED OUTPATIENT TREATMENT PLAN, PLEASE LET OUR OFFICE KNOW SO THAT WE MAY SEND AN UPDATED ONE TO YOUR INSURANCE PROVIDER IN A TIMELY MANNER.

OBTAIN CLAIM MAILING ADDRESSES SO THAT YOU MAY SEND IN YOUR RECEIPTS DIRECTLY TO YOUR PROVIDER.

THE RECEIPT YOU RECEIVE FROM RITA PRELLER, LCSW-C WILL HAVE ALL THE INFORMATION NEEDED FOR YOUR INSURANCE PLAN TO PROCESS YOUR CLAIM AND REIMBURSE PAYMENT DIRECTLY TO YOU.

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It is important to understand that people have different insurances. In addition, there are multiple plans within each insurance, so people having Carefirst, for example can have vast differences in their coverage. Benefits vary, as do deductibles, authorizations/referral requirements, and in and out of network coverage. You must determine what your insurance requires, so when you submit claims, you minimize administrative reasons for denials.

>Submit treatment plans to your plans mental health administrator, if required

>Send your monthly bills

>Send you receipts for your payments

>Send you an update on the client, if requested by the insurance company

For Carefirst Insurances:

Determine if you need authorizations for coverage. You can call Carefirst and inquire directly if you don't know for sure. Once you have determined an authorization is required, you need to call Rita Preller, LCSW-C and ask her to submit a treatment plan directly to them. There is a specific form for this authorization. Once a treatment plan has been submitted by Rita Preller, LCSW-C to the insurance administrator, you should receive a letter from the administrator authorizing specific services. On the treatment plan, Rita Preller, LCSW-C will request a specific number of group sessions as well as individual or family sessions. There are codes for these different sessions. For example, a group session is coded 90853 while an individual session is coded as 90806. The treatment plan should specify how many visits of each are being requested. I recommend that everyone request authorization for services rendered from the inception of treatment. The worst that can happen is that they deny it.

Claim Forms:

It is recommended using the attached claim forms, and NOT the forms that Carefirst may send you. These are some tips for completing your claim form. Make sure the top portion of the form is completed correctly. This is the demographic information which includes the policy holder's information as well as the patient's information.

The policy holder is the person whose name is on the policy, usually the parent or spouse. Make sure that line 12 states "Signature on File". Box 21 is for the diagnosis codes. This code should be provided by you by Rita Preller, LCSW-C and can be found on your receipt from Rita Preller, LCSW-C. There are usually one or two diagnosis codes. Box 24 asks for the actual claim information. This includes the date of service, place of service, procedure code, diagnosis pointer, charge, and number of units. Do not worry about other boxes. Box 25 is Rita Preller, LCSW-C's Federal Tax ID number which can be found on the receipt from Rita Preller, LCSW-C. Box 27 needs to be checked "NO". Make sure that you fill out both box 28 and 29 and then they are the same amounts. Box 31 asks for the treating therapist. You would fill in the box with "Rita Preller, LCSW-C". Box 32 asks the name of and address of office. Box 30 is the billing provider's name which is the same as Box 31.

Once you have filled out the claim form, make copies of the claim form and also make a copy of the receipt from Rita Preller, LCSW-C for your records. You are now ready to submit your claims. It is usually best if you save up a few bills and submit together rather than one at a time. You have up to six months to submit bills.

**OTHER SUGGESTIONS:**

If you have coverage, there is no reason why you should not be reimbursed. Do not accept denials for claims without a fight. Most of the time, there is some small detail that was left out. You can resubmit a corrected claim. You must read the denial code on the voucher that they send you in order to make the appropriate correction. Once you do this, you need to keep a paper trail of all claim submissions, correspondence, and document any telephone calls with the name of the person you have spoken to. This is vital if you wind up having to appeal claim denials.