

Christiane Elsbree, MSW, LICSW
6300 - 9th Avenue NE, Suite 340
Seattle, WA 98115
(206) 522-0269

If you wish me to bill your health benefit plan for outpatient mental health services please complete the following:

Carrier Name: _____

Send Claims to: _____

Phone # re Claims Questions: _____

Subscriber/Insured Name: _____

Subscriber/Insured ID #: _____

Address: _____

Employer: _____

Group #: _____

Patient's Name: _____

Birthdate: ____ / ____ / ____

Patient's Relationship to Subscriber: Self Spouse Child Other

Is there another health benefit plan? Yes No

If yes, please provide information:

Other Insured's Name: _____

Birthdate: ____ / ____ / ____

Other Insured's ID #: _____

Address: _____

Employer: _____

Group #: _____

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SOME QUESTIONS TO ASK YOUR HEALTH PLAN CARRIER RE YOUR COVERAGE

Do you have coverage for outpatient mental health services? yes no
What is the effective date of coverage? _____

Is there a waiting period for preexisting conditions? yes no
Have you satisfied it? yes no
If not, when will it end? _____

How many out-patient mental health visits are allowed per calendar year? _____

Do you have to satisfy an annual deductible? yes no How much? _____
Has it already been met for this year? yes no

What is your copayment? _____
Are you additionally required to pay a percentage of the fee? _____

Is "Christiane Elsbree", a preferred provider with your plan (refer to my business card for my credentials)? yes no "in-network" or "out-of-network"

Do you have coverage for these current procedural codes? 90806 90847 90846 90853
couples or family visits: CPT Codes 90846 & 90847
group visits: CPT Code 90853
individual visits: CPT Code 90806

My fee is \$100 (subject to change) per visit for CPT Codes 90806/90847/90846.
What can you expect your portion of the charges to be? _____

Does your health benefit plan require pre-authorization or referral for individual psychotherapy (CPT Code 90806)? yes no
What documentation needs to be submitted to receive authorization for additional visits?

How frequently do they need to be submitted? _____
Who reviews them? _____

Agreement to Pay:

I understand that I am responsible for payment for all services rendered. Payment at each session is preferred. When I am billed for balances not covered by my health plan, I understand that payment is to be made within thirty days of receipt of statement. I further understand that I will be charged full fee (\$100) unless otherwise stated for all missed appointments not cancelled at least 24 hours in advance. My health benefits plan will not be billed for those appointments.

Signature _____ Date _____

Please sign authorizations in boxes 12 & 13 of the HCFA-1500 billing form