OUT OF NETWORK BENEFITS

Questions to Ask Your Insurance Provider

Many private insurance companies provide out-of-network benefits that enable you to submit claims and receive reimbursement for a significant portion of therapy costs. To fully understand and utilize these benefits, it's essential to ask your insurance provider detailed questions about coverage, reimbursement rates, deductibles, session limits, and the claims process. The following guide will help you navigate these inquiries, ensuring you have all the necessary information to make informed decisions about your mental health care.

REIMBURSEMENT AND COVERAGE DETAILS

- Do I have out-of-network benefits for mental health or therapy services?
- What is the process for using out-of-network providers?
- What is the reimbursement rate or percentage of the fee that you cover for out-of-network mental health services?
- What is the out-of-pocket maximum for out-of-network services?

DEDUCTIBLES

- Is there a yearly deductible for out-of-network services, and if so, what is it?
- Is my mental health deductible part of, or separate from, my medical deductible?
- How much of my deductible have I met this year?

LIMITS AND RESTRICTIONS

- Are there any limits on the number of sessions covered per year for out-of-network services?
- Are there any specific types of therapy or services that are not covered out-of-network?

CLAIM SUBMISSION

- What information do I need to submit a claim for out-of-network services?
- How do I submit a claim for out-of-network services?

PRE-AUTHORIZATION AND REFERRALS

- Do you require pre-approval or pre-certification of sessions?
- Who must obtain the pre-approval or pre-certification?
- How is this done?

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