Omaha Integrative Care
Benefits Verification Form

Omaha Integrative Care Information:
1812 N. 169th Plaza, Omaha, NE 68118
17021 Lakeside Hills Plz, Ste 101 Omaha, NE 68130
Tel. 402-934-1617 Fax 402-934-5228
Tax Identification Number: 45-1798468
Group NPI: 1023302247

Please complete this form prior to your first appointment or at the time of any change in your insurance.

Information from your insurance card:

Primary Insurance

Client Name: _____ DOB: _____

Insured's Name: _____ DOB: _____

Insurance Company: _____

Member ID# _____ Group#_____

Employer_____

Mental Health Phone/Customer Service Phone # _____

Claims Mailing Address: _____

Secondary Insurance (if applicable)

Client Name: _____ DOB: _____

Insured's Name: _____ DOB: _____

Insurance Company: _____

Member ID# _____ Group#_____

Employer_____

Mental Health Phone/Customer Service Phone # _____

Claims Mailing Address: _____

Tertiary Insurance (if applicable)

Client Name: _____ DOB: _____

Insured's Name: _____ DOB: _____

Insurance Company: _____

Member ID# _____ Group#_____

Employer_____

Mental Health Phone/Customer Service Phone # _____

Claims Mailing Address: _____

Call to insurance company for Mental Health or Behavioral Health:

1. Call the toll free number on the back of your card.

2. Ask for "Outpatient Mental Health Benefits" or "Behavioral Health Benefits."

3. When asked for the provider's name, tell the person your therapist's name at "Omaha Integrative Care."

Please record all information below.

Name of insurance customer service representative: _____

Date of phone call: _____

Coverage period: From _____ to _____

Deductible: Amount $_____ Per _____ How much has been met? $_____

Is this the primary or secondary insurance? _____

Is there a session limit? _____ If yes, allowed # of sessions _____ per _____ (calendar year, etc.)

Covered Credentials: PLHMP LMHP LCSW LIMHP LICSW APRN

Provider Name: _____ Is provider in or out of network? _____

Are the following services covered (please circle all that apply):

Initial diagnostic visit CPT Code:	90791 (therapy)		90792 (Psychiatric Med)
Individual therapy/counseling CPT Codes:	90832	90834	90837
Family therapy/counseling CPT Codes:	90846	90847	96153
Group Therapy/Bx Health CPT Code:	90853	96153	

Is authorization/Pre-cert needed (please circle): Yes No

Pre-cert Phone #: _____ Auth# _____ from ____ to _____

Covered services for authorization: _____

Benefit Information:

	In-Network	Out-of-Network
Co-pay		
% of Coverage		

EAP or Other Insurance Information:

If this is an EAP benefit please provide the following information:

EAP Plan Name: _____ Employer: _____

Billing/Claims Address: _____

Authorization Number: _____ Number of sessions: _____

CPT codes with modifiers if necessary: _____

Call to Insurance Company for Medical:

1. Call the toll free number on the back of your card.

2. Ask for “Medical Benefit Coverage.”

3. When asked for the provider’s name, tell the person provider’s name at “Omaha Integrative Care.”

Please record all information below.

Name of insurance customer service representative: _____

Date of phone call: _____

Coverage period: From _____ to _____

Deductible: Amount $_____ Per _____ How much has been met? $_____

Is this the primary or secondary insurance? _____

Is there a session limit? _____ If yes, allowed # of sessions _____ per _____ (calendar year, etc.)

Provider Name: _____ Is provider in or out of network? _____

Is authorization/Pre-cert needed (please circle): Yes No

Pre-cert Phone #: _____ Auth# _____ from ____ to _____

If there is another payor or contract please list below:

Other Payor Information:

Auto Insurance
Name: _____ Policy Number: _____

Billing/Claims Address: _____

Other Contract/Responsible Party:

Name: _____ Case/Policy Number: _____

Billing/Claims Address: _____

I understand that this is the information provided to me by my insurance company and that Omaha Integrative Care can not guarantee the accuracy of this information or any other information from third party payors. I understand that it is my responsibility to understand these benefits and how they will impact my financial responsibility for services at Omaha Integrative Care. I understand that I am responsible for any charges not covered by a third party payor including, but not limited to, co-pays, co-insurances, deductibles, non-covered services, returned check fees, late cancelation fees and not no-show fees.

_____ _____

SIGNATURE DATE

_____

NAME