

INSURANCE COVERAGE INQUIRY

Have your insurance card available when you call and bring the completed form to your first visit.

Insurance Company Name _____

Company Telephone _____

1. My selected provider is **Dr. Elizanda de la Sota (Psychologist)**
Is she currently a network provider under my plan?

2. **If YES, In Network Benefits applies.**

Is **Pre-Authorization** required? Yes ___ No ___

How do I request authorization? _____

Is there a **DEDUCTIBLE**? If yes, How much is it? _____

How much of it has been met? _____

Which CPT codes are allowed?

90791 (Initial Evaluation)= Yes ___ No ___

90834 (Individual Therapy)= Yes ___ No ___

90847 (Family or Couples Therapy)= Yes ___ No ___

90846 Family therapy without the patient present) _____ =Yes ___ No ___

What is the **Co-Pay** per session? _____

3. **If NO, Then I am NOT in the network. Therefore, you pay the full session fee, I give you the receipt to file with your insurance and your insurance will reimburse you for some part of the fee.**

4. Are there **EXCLUSIONS** to my coverage for specific types of treatments or conditions?

Is **Family Therapy** covered?

Is **Couples Therapy** covered?

Are there any specific conditions that are **NOT** covered?

Are **Pre-Existing conditions** covered?

5. What is the **Claims mailing address**?

CLAIMS ADDRESS=

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