DONNA HAMPTON
counseling.

MS | LCMHCS | NCC | EMDR-Certified Therapist

Client Name _____ Date Completed _____

I require that new clients check their insurance benefits ***before*** their initial appointment in order to determine the appropriate charges for counseling services. I am **In-Network with most Blue Cross Blue Shield of North Carolina (BCBSNC) plans and with Carolina Behavioral Health Alliance (CBHA)**. *Checking your benefits <u>does not guarantee</u> payment.* I am willing to apply for **Out-of-Network** benefits on a case-by-case basis, as well; please understand that ***clients remain fully responsible for all counseling fees*. It is only <u>after</u> your insurance company has made its first payment that you can be guaranteed the coverage amount.**

You will need to bring <u>this completed form</u> and <u>your current insurance card</u> to your initial counseling session.

1. Contact your insurance company at the customer service number (usually found on the back of your insurance card). When you contact customer service, let them know that you are calling to determine your **mental health office visit benefits**. This term simply means that you are asking about mental health benefits and that Donna Hampton's counseling services are provided in an office setting, rather than in a facility or inpatient setting.
    a. Your insurance company may require the following numbers for Donna Hampton's services:
        i. Tax ID # 47-5071754
        ii. **National Provider Identification # (NPI #) 1407032576**

2. Make sure you receive the following information:
    a. Is Donna Hampton an In-Network Provider with MY plan? ❑Yes ❑No
    b. Do I have a **Deductible**? ❑Yes ❑No
        i. If Yes, how much? $_____
        ii. If Yes, has any of my Deductible been met? ❑Yes ❑No
        iii. If Yes, how of my Deductible much has been met? $_____
        iv. How much remains BEFORE I meet my Deductible? $_____
        v. If I **have not met my** Deductible, what is MY Fee for Counseling? $_____
    c. **When** does this Deductible renew (January 1 or another date)? _____
    d. Do I have a **Co-Pay** or **Co-Insurance**? ❑Yes ❑No
        i. If Yes, what is the **amount**?
            1. Co-Pay $_____ OR Co-Insurance $_____ OR %_____
    e. Is there a **limited number** of visits per year? ❑Yes ❑No
        i. If Yes, **how many** visits? _____
        ii. If Yes, what is the Calendar Year (i.e. January –December, etc.)? _____
    f. Do these counseling services require Authorization? ❑Yes ❑No
        i. If Yes, what is my **Authorization Number**? _____

It may be helpful for you to have service code for the most common service provided by Donna Hampton:

Psychotherapy 60 minutes: **90837** (typical Individual Counseling Session)

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