LAUREL THERAPY COLLECTIVE

Insurance Fact-Check Worksheet

For checking your coverage for reimbursement for therapy services

Ins. Provider: _____ Member services #: _____

Call date: ___/____/____ Representative name: _____

1) **What is my insurance amount covered per each individual** (CPT:90834) **/couples** (CPT:90837) **session with an out-of-network behavioral health provider with an LMFT license?** (This will be a flat fee or a percentage of the total cost): _____

2) **What is my insurance plan deductible?** (if applicable): $_____

3) **What is my per-session copayment** (flat fee) **or coinsurance** (percent) **amount?:** _____

4) **How many visits or sessions will be covered?** (if applicable): _____

5) **When does my insurance coverage start and renew?**

   Effective: ___/____/____ Renew: ___/____/____

6) **How much of my deductible have I met so far this year?** (if applicable): $____

7) **Does my plan cover behavioral health visits offered via telehealth?** Y / N

8) **What is the process for submitting a reimbursement claim?**

This worksheet is provided as an informational tool and does not guarantee insurance reimbursement.

Laurel Therapy Collective
Mailing address: 2355 Westwood Blvd #549, Los Angeles CA 90064
EIN: 87-4134155 NPI: 1669132973
www.laureltherapy.net
415-504-2895