

Mental Health Insurance Verification Checklist

Use before a new patient's first session, when a plan changes, and at the start of each year. Patient:

_____ Date: _____ Verified by: _____

1. Patient and policy

- ☐ Name, date of birth, member ID and group number match the insurance card
- ☐ Plan is active on the date of service (note any termination date)
- ☐ Whether mental health benefits are handled by a separate behavioral health plan, and where to send claims
- ☐ Your practice and rendering clinician are in network, or out-of-network benefits apply

2. Mental health benefits

- ☐ Covered CPT codes for your services (for example 90791, 90832, 90834, 90837) and any that are excluded
- ☐ Visit limits per year and how many visits are already used
- ☐ Deductible amount and how much is met; copay or coinsurance per session
- ☐ Family therapy (90846 / 90847) and group therapy (90853) coverage, if you provide them
- ☐ Any limits on 90837 (60-minute sessions) or extra documentation the plan requires

3. Authorization

- ☐ Is prior authorization required? For which codes, and after how many visits?
- ☐ Authorization number, approved number of visits and the start and end dates
- ☐ How to request more visits before the authorization runs out

4. Telehealth

- ☐ Telehealth covered for video and for audio-only sessions?
- ☐ Place-of-service code the payer wants (POS 10 = patient at home, POS 02 = elsewhere)
- ☐ Modifier the payer requires (for example 95 for video, 93 for audio-only)

5. Claims and deadlines

- ☐ Timely filing limit for claims and the deadline for appeals
- ☐ Claims address or payer ID for electronic claims

6. Record the call

- ☐ Call reference number, representative name, date and time
- ☐ Save the eligibility response or call notes to the patient's file
- ☐ Tell the patient their estimated cost per session before the first visit

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