ABOUT USING YOUR HEALTH INSURANCE FOR COUNSELING SERVICES

I am happy to work with you to use your health insurance to cover the cost of our counseling work. Please review the following carefully.

Insurance

If you are insured with Blue Cross, Regence and Select Health

I am an in-network provider with the above named insurance companies, and am happy to direct bill them for your sessions.
This means you pay only your co-pay at the time of service, and I bill for the balance of my fee.
If you wish to use your insurance for our work please do the following:

1. Review your policy to be sure you have Mental/Behavioral Health coverage.
2. Understand the terms and conditions e.g., is there a limit to the number of sessions covered, and if so, what is that limit?
3. Have you met any relevant deductible?
4. Clarify your co-pay – this will be due to me when we meet.
5. Complete the attached form asking for your insurance info.
6. Bring your Insurance Membership Card to the 1st & 2nd sessions.

If you are insured with a provider other than those mentioned above

I *may* be in-network, or I may be considered out-of-network, but in either case I have chosen not to use any on-line Direct Claims Entry system. This simply means you pay my fee up front and then submit the claim yourself. If you wish to use your insurance for our work please do the following:

1. Review your Health Insurance Policy. Call customer service and be sure you understand their answers to question 1 – 4 above.

2. Clarify whether I am an in-network or out-of-network provider. Your insurance company may need to know ~

a. My Idaho MFT license info: Idaho license # 5704
b. My NPI (National Provider Identity): 1386 024 602
c. My Business Tax ID#: 47-1125545I

2. If I am in your insurance network, clarify how you will be reimbursed. Usually I complete the Providers section of a Form 1500 and you complete the patient section. Please get the address for where this form should be sent. While I will be an active participant to help you get reimbursed, it is ultimately your responsibility to pursue reimbursement.

3. If I am out of your insurance network, clarify what the company pays for out-of-network providers. Some companies are very generous and will

reimburse you 60% of my fees. Most are between 40 and 50% - so it is still very much worth doing.
As with in-network companies, usually I complete the Providers section of a Form 1500 and you complete the patient section. Please get the address for where this form should be sent. While I will be an active participant to help you get reimbursed, it is ultimately your responsibility to pursue reimbursement.

Important Information Regarding Submitting an Insurance Claim.
Please know that insurance companies will only reimburse you or me for Mental Health or Behavioral Health services that are "medically necessary." This means they will only pay if you (or your partner or family member) are diagnosed with a mental health disorder that is currently impacting your health on a day-to-day basis.
Presuming there is a legitimate diagnosis that is preventing optimal functioning for you or a member of your family, I am happy to discuss both my diagnosis and the implication of this diagnosis for ongoing health, wellness and treatment.

Whilst I believe the three issues below are important, life enhancing and powerful preventative "treatments", sadly they are not covered by insurance:

1. Psychological or spiritual growth;
2. Pre-marital counseling;
3. Couples Counseling (unless one or both partners has a diagnosis).

FEES AND PAYMENT
My sessions last for one hour. I charge $100 an hour. Fees are due at time of treatment. I accept cash, checks, credit cards and HAS account funds.

HEALTH INSURANCE ~ STATEMENT OF UNDERSTANDING & RESPONSIBILITY

Please PRINT VERY CLEARLY

Client(first) _____ (last) _____

Date of Birth (month) _____ (day) _____ (year) _____

Preferred Phone #_____

Home Address _____

PRIMARY INSURANCE INFORMATION

Insurance Company _____

Insurance Company Phone _____

Name of Primary Insured _____

Insured's DOB (month) _____ (day) _____ (year) _____

Insured's Identification #_____

Insured's address _____

Insured's Employer / School _____

FINANCIAL UNDERSTANDING & AGREEMENT

I plan to use my Health Insurance to help offset these costs. (Please check one of the 3 options below.)

___ I am insured through Blue Cross, Regence or Select Health & my co-payment is $ ____

___ My insurance is other than those listed above. I will pay Gemma Utting at the time of service, and submit Form 1500 for insurance reimbursement.

IF YOUR INSURANCE MONEY CANNOT BE COLLECTED, YOU ARE RESPONSIBLE FOR THE FULL AMOUNT.

"I authorize the release of information necessary to process my insurance claims. I also authorize payment of any benefits from the insurance company(s) listed above to be paid to Gemma P. Utting, MA, LMFT for services rendered by her."

Client Signature_____Date _____