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Insurance Verification Form - OT & SLP

The following page must be completed and delivered or faxed to 734-527-5981. If you are comfortable emailing protected health information, you may choose to email the completed form to info@arborautismcenters.com. By doing so, you acknowledge you are sending PHI using an unsecure method which may compromise the confidentiality of the information being sent.

Calling the insurance company to verify what services are covered for Autism Spectrum Disorder will guide the next steps for your child (and help prevent unnecessary evaluations or testing). Insurance plans vary a lot, even within the same insurance company, and it is not uncommon to speak with an insurance representative who mistakenly gives you incorrect information. If you are a parent new to understanding your benefits and what is covered, this misinformation could keep you from getting the services your child qualifies for. These suggestions will help you best direct the call representative to the autism portion of your plan and document the call.

First, have the following page ready to write down your information, then call the number on your insurance card. Tell them that your child has an autism diagnosis, and you would like to know, **"Is there a limit to speech therapy/occupational therapy/physical therapy sessions if my child has an autism diagnosis?"** Tell them you are aware that these services have a different level of coverage when a child has an autism diagnosis and that you would like them to first check what is covered under the autism section of your plan. For some plans, this may be found under Behavioral Health.

After the representative answers your questions on the following form, repeat the answer back for clarification. For example, **"So with an autism diagnosis, there is no limit to speech therapy visits, correct?"** Write down this information on the following page and repeat again what you have written down. **After confirming all the needed information, ask for the reference number of your call.** This will ensure that you and the insurance company representative have a record of your conversation. If you run into problems with billing, the call reference number can be very helpful.

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OT & SLP Insurance Verification Form

PATIENT NAME: _____

Prior to your initial therapy visit, you will need to contact your insurance provider to verify coverage for services, complete this form, and deliver or fax it to 734-527-5981. If you are comfortable emailing protected health information, you may choose to email the completed form to info@arborautismcenters.com. Therapy sessions can be billed at costs over $300 per session and you may be responsible for up to that amount until your deductible is met. It is important that you are aware of any potential costs you may incur.

Please be aware that it is also the responsibility of the patient's parent/guardian to inform Arbor Autism Centers via the patient portal of future changes in insurance providers/benefits. Failure to update insurance coverage information may result in denial of services.

All patients will be responsible for charges that are not covered by insurance.
BCBS and BCN: Arbor Autism Centers is a Tier 2 provider for OT & SLP, your deductible may apply.

Date of call: _____ **Time of call:** _____

Name of the insurance representative with whom you spoke: _____

The representative will ask for the following information:

Diagnosis code(s): **F84.0** Autism

Procedure code(s): ☐ **92507** Speech therapy ☐ **92508** Speech group therapy
☐ **97530** OT therapy ☐ **97535** OT Daily Living Activities ☐ **97110** OT Exercises

Is prior authorization required for therapies if billed as diagnosis code F84.0 Autism? ☐ Yes ☐ No
Is there a visit limit for therapies if billed as diagnosis code F84.0 Autism? ☐ Yes ☐ No
If yes, #of visits allowed: _____

Do multiple therapy appointments (OT & SLP) on the same day count as one visit? ☐ Yes ☐ No
Do multiple procedures (ex: 92507 & 97530) on the same day count as one visit? ☐ Yes ☐ No
Are virtual therapy visits covered? ☐ Yes ☐ No

Deductible: _____ **Does the deductible apply to OT or SLP Therapy?** ☐ Yes ☐ No
Is there a copay or co-insurance after meeting deductible? ☐ Yes ☐ No **Copay/Co-Ins:**_____
Are there limitations to this coverage?
_____

IMPORTANT - Reference number for the call: _____

Parent/Guardian Printed Name:_____

Parent/Guardian Signature:_____ **Date:** _____

Rev 11/08/2023