Sojourn Mental Health, LLC
Mental Health Insurance Coverage Information Form

Dear Client,

We look forward to seeing you and we will gladly file your sessions with the counselor to your insurance company. However, we do not verify coverage or call to get the information concerning your coverage for you. I will need a copy of your Insurance Card, in addition I need you to call the phone number(s) on your health insurance card to get the following information PRIOR to your first session. Without ALL questions on this form answered by your Insurance Company, you will be responsible for the full session fee. ** Please note that Sojourn Mental Health, LLC has LPCs that are credentialed with **Blue Cross Blue Shield ONLY.** Please do not write any other information on this form, or add "secondary policies" other companies or medicaid/medicare information**

Client's Name: _____ Date of Birth: _____
Insured's Name: _____ SS#: __-__-___ Relationship _____
Blue Cross Blue Shield Policy ID# : _____ Effective date: _____
Insured's employer: _____ Group Numbers: _____

You must call the number on your insurance card and ASK THESE QUESTIONS: Ask for a reference number regarding your phone call. Ref. # _____

Do I have outpatient mental health benefits? Yes_____ No_____
Is Jarrod Hegwood LPC (Sojourn Mental Health, LLC) on my provider list? Yes____ No____
If no, do I have any "out of network" benefits? Yes_____ No_____
(Write what those benefits are on the back of this form)
Do I have a deductible to meet prior to benefit coverage? Yes_____ No_____
What is the amount of my deductible? $_____
How much of that deductible have I met? $_____
Do I have a co-payment for mental health benefits? Yes _____ No_____
If so, what is my co-payment amount per session? $_____
How many sessions are allowed per calendar year? _____
Is prior authorization needed for counseling? Yes_____ No_____
If so, authorization number? _____

PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE: I authorize the release of any medical or other information necessary to process claims. I authorize payment of medical benefits to the counselor who provided the service.
SIGNED: _____ DATE: _____