Angela Hunnicutt, Ph.D., HSPP, CPC
9247 N. Meridian St., Ste. 104
Indianapolis, IN 46260
(317) 815-6030
Fax: (317) 815-6031
www.psychotherapyandlifecoaching.com

BILLING/CLAIM INFORMATION

Questions to ask your insurance company:

1) *What is the name of the company/managed care organization for mental health?*
2) *Is ASH Psychological Services, P.C./Dr. Hunnicutt in network for 9247 N. Meridian St., Ste. 104, Indianapolis, IN 46260 and Tax ID # 263280205?*
3) *If ASH Psychological Services, P.C./Dr. Hunnicutt is in network, is prior authorization required, what is my co-pay or co-insurance and deductible, and is there a maximum number of visits per year?*
4) *If prior authorization is required, what is the authorization number, how many sessions were authorized, and what are the start and finish dates of authorization?*
5) *If ASH Psychological Services, P.C./Dr. Hunnicutt is not in network, what are my "out-of-network" benefits, what is reimbursement rate and deductible, is prior authorization required, and is there a maximum number of visits per year?*

Name of Client:_____ Name of Insured:_____ Relationship to Client:_____
DOB of Client:___/____/_____ Gender of Insured: M/F DOB of Insured:____/____/_____
Address of Insured:_____ City:_____ State:____ Zip:_____
Employer of Insured:_____
Employer Address:_____ City:_____ State:___ Zip:_____
Insurance Company ID #:_____ Group #:_____

Prior Authorization required for Mental Health? YES/NO Prior Authorization #:_____
Number of sessions pre-authorized?_____ Start date for authorization:_____ End date for authorization:_____
Co-pay/Co-insurance? YES/NO If YES, how much is it?_____ Deductible? YES/NO If YES, for how much?_____
Has your deductible been met this year? YES/NO If NO, how much remains?_____ Maximum # of visits/yr._____
Effective date of coverage?_____ Date coverage ends:_____
If you have additional plans, please complete additional sheets.

Insurance Company/Third Party Payor/Financially Responsible Individual Name:_____
Billing/Claim Address:_____
City: _____ State:_____ Zip:_____

Payment/Release of Information Authorization: I authorize the submission of bills/claims to my insurance company (including managed care company, Employee Assistance Program, or their designees) and/or above third party payor for reimbursement for services rendered by Dr. Hunnicutt. I authorize the release of any and all protected health information, including mental health, substance abuse, assessment and treatment information, necessary to request benefits, authorization, or payment from a third party payor and/or my insurance carrier. I authorize all medical benefits payable under my insurance policy to ASH Psychological Services, P.C. so that payments may be applied to my account. Any unpaid portion, including for non-covered services, is ultimately my responsibility unless payment is prohibited by contract between Dr. Hunnicutt and the insurer and/or third party payor.

_____ _____
Client or Parent/Guardian Signature Date

_____ _____
Angela Hunnicutt, Ph.D., HSPP Date

I have insurance, but I do not want Dr. Hunnicutt to file a claim with my insurance company or send information about my treatment to the insurance company. I understand that life or long-term care insurance may require such information.

_____ _____
Client or Parent/Guardian Signature Date

_____ _____
Angela Hunnicutt, Ph.D., HSPP Date

Revised March 2014