



## How to Complete the Insurance Verification Form

Prior to your child's initial assessment, please complete the following form with information provided by your health insurance company. You may download the form and upload the completed version to your patient portal or fax it to 734-527-5981. If you are comfortable emailing protected health information (PHI), you may choose to send the completed form to [info@arborautismcenters.com](mailto:info@arborautismcenters.com). By emailing, you acknowledge that you are sending PHI using an unsecured method, which may compromise the confidentiality of the information being sent.

Health insurance plans vary significantly, even within the same company, and it is not uncommon to receive incorrect information from an insurance representative. If you are new to understanding your benefits and coverage, this misinformation could prevent your child from receiving the services they qualify for. This form will help you direct the call representative to the autism part of your insurance plan and document the call effectively.

### Steps to Complete the Form:

1. **Preparation:** Have the form ready to record your information. It will guide the next steps for your child and help prevent unnecessary evaluations or testing.
2. **Contact Insurance:** Call the number on your insurance card, then ask to speak to a representative in eligibility and benefits. *Do not use the automated service, as it will provide information on general therapy benefits only.* A diagnosis of autism unlocks additional benefits for members under 19 years of age and should not have a visit limit or require prior authorization. You may need to stress that the therapy services will be billed under diagnosis code F84.0 Autism Spectrum Disorder, and that the representative may need to look under a contract rider or Behavioral Health.
3. **Document Information:** Record the information provided by the insurance representative on the form. Repeat the information to ensure accuracy.
4. **Reference Number:** Ask for the reference number of your call and record it at the bottom of the form. This will ensure that both you and the insurance company representative have a record of your conversation. The reference number can be extremely helpful if you encounter any billing issues.



## Insurance Verification Form – Applied Behavior Analysis (ABA)

Patient Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Prior to your child's initial assessment, please complete the following form with information provided by your health insurance company. You may download the form and upload the completed version to your patient portal or fax it to 734-527-5981. If you are comfortable emailing protected health information (PHI), you may choose to send the completed form to [info@arborautismcenters.com](mailto:info@arborautismcenters.com). By emailing, you acknowledge that you are sending PHI using an unsecured method, which may compromise the confidentiality of the information being sent.

**All patients will be responsible for charges that are not covered by insurance.** 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 and benefits. Not updating your insurance coverage may result in a denial of payment, for which you will be responsible.

**BCBS and BCN: Arbor Autism Centers is a Tier 2 provider for OT & SLP, your deductible may apply.**

**Please complete:**

Date of call: \_\_\_\_\_ Time of call: \_\_\_\_\_

Name of the insurance representative with whom you spoke: \_\_\_\_\_

Deductible: \_\_\_\_\_ Maximum Out of Pocket: \_\_\_\_\_

Reference number for the call: \_\_\_\_\_

Parent/Guardian Name: \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Then, please ask and record the answers to all the questions on the next page.**



## Insurance Verification Form – Applied Behavior Analysis (ABA)

Patient Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

**Please ask the insurance representative to check the following ABA Therapy procedure codes for coverage if billed under diagnosis code F84.0 Autism and mark as yes or no.**

**Please stress the diagnosis code F84.0.** The representative may have to look under your autism specific benefits or rider. It is **unusual** for prior authorization to be required or visits to be limited, especially for Michigan-based plans. Please indicate yes or no.

97151 Initial ABA Assessment/Re-Assessment

97153 Line Therapy

97154 Group Line Therapy

97155 Supervision

97156 Caregiving Meeting/Guidance

97158 Group Adaptive Behavior Treatment

**Please ask and record the answers to all questions below:**

**1.** Is prior authorization required for ABA therapy?

**2.** Are virtual ABA therapy visits covered?

**3.** Does the deductible apply to ABA therapy visits?

**4.** Is there a copay or co-insurance after meeting deductible?

If yes, what is the copay or co-insurance: \_\_\_\_\_

**5.** Are there limitations to this coverage?

If so, what are they?