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. 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 – Feeding Therapy

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. By doing so, 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 pf payment, for which you will be reponsible.

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.

ARBOR AUTISM CENTERS

Insurance Verification Form – Feeding Therapy

Patient Name _____ **Date of Birth** _____

Please ask the insurance representative to check the following diagnostic codes for coverage:

Yes No F84.0 Autism

Yes No R63.3 Feeding Difficulties

Yes No R62.51 Failure to Thrive

Yes No R63.31 Pediatric Feeding Disorder - Acute

Yes No R63.32 Pediatric Feeding Disorder - Chronic

Please ask the insurance representative to check the following Feeding Therapy procedure codes for coverage and insurance referral / prior authorization requirements:

Yes No 92610 Evaluate Swallow Function

Yes No Is ins referral required for 92610?

Yes No Is prior auth required for 92610?

Yes No 92526 Oral Function Therapy

Yes No Is ins referral required for 92526?

Yes No Is prior auth required for 92526?

Please ask and record the answers to all questions below:

1. Is there a visit limit for feeding therapy?

Yes No **If yes**, number of visits allowed: _____

2. Do multiple therapy appointments (OT and SLP Feeding) on the same day count as one visit?

Yes No

3. Do multiple procedures (ex: 92526 and 92507) on the same day count as one visit?

Yes No

4. Are virtual feeding therapy visits covered?

Yes No

5. Does the deductible apply to feeding therapy visits?

Yes No

6. Is there a copay or co-insurance after meeting the deductible?

Yes No **If yes**, what is the copay or co-ins: _____

Are there limitations to this coverage?

Yes No

If so, what are they?