OUT OF NETWORK INSURANCE BENEFITS WORKSHEET

Mental Health Insurance (MHI) Company Name: ______________________________________

Policy Number: _________________________________ Group Number: ________________

Name of Policy Owner: __________________________ DOB of Policy Owner: ___________

MHI Claims Address: ____
Street/PO Box

____
City State Zip

MHI Phone Number: ___________________ Authorization/Precertification Required: Y N

Specific claim form required: Y N

If so, where can the form be found on-line: ____

Out-of-Network Benefits: Level of benefits applied when using a provider who is not a member of your insurance network. You will likely be covered, but you may pay a higher copayment, deductible, and/or coinsurance. You are responsible for any amounts incurred in excess of the "covered charges." "Covered charges" are pre-determined **U**sual, **C**ustomary and **R**easonable charges (UCR) for a particular service. Covered charges may vary from one geographical area to another. Out-of-Network providers may require you to pay for services at the time of service and you will have to file a claim with the Plan in order to be reimbursed.

$ _______ **Deductible:** An amount to be subtracted from the amount or amounts otherwise payable as Covered Medical Expenses under your Plan before payment of any benefit is made. The deductible will apply per policy year.

Has deductible been met? Y N
If the deductible has not been met, the remaining amount to be paid is $ _____

$ _______ **Co-pay**: The amount an insured person is expected to pay for a medical expense at the time of the visit.

% ______ **Co-Insurance**: The percentage of Covered Charges for which you are financially responsible and which shall not otherwise be payable under the terms of the Plan; provided, however, any such Coinsurance shall be determined after any Deductible amount is applied.

Number of visits per year (if applicable) ___How many visits remaining (if applicable)? ____