**Phoenix Counseling Group and Play Therapy Center, PLLC**
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www.phoenixfamilycounseling.com

# BENEFITS INFORMATION SHEET

**THIS INFORMATION MUST BE COMPLETED PRIOR TO YOUR INITIAL APPOINTMENT AND BROUGHT TO THE FIRST APPOINTMENT**

**When you call your insurance company, please specify that you need your OUTPATIENT MENTAL HEALTH benefits. (Note that your medical insurance provider may not be the same insurance company that provides your mental health benefits.)**

Client Name: ____________________________ Date of Birth: ________________

Insurance carrier: _____________________________ ID #: ________________

Insurance Contact No.: __________________ Spoke With: ________________

QUESTIONS TO BE ASKED:

Co-pay Amount: $__________________

Do I need Pre-authorization? Y N If yes, Authorization No.: ___________________
Number of Visits allowed? _____________________

Is my limit per calander year or contract year? ________________________________
If contract year, when does my contract year start? ____________________________

Do I have an annual deductible? Y N If yes, amount: $______________________
Have I met my deductible? Y N If no, how much is left? $__________________

Does my therapist have to complete any treatment requests? Y N
If yes, after how many visits? ___________________

IF YOU HAVE CAREFIRST:

Are your mental health benefits through Magellan? Y N
If yes, Do you have out-of-network benefits? Y N
If no, please note that you may have benefits that Phoenix Counseling Group and Play Therapy Center, PLLC may not be paid for by your insurance carrier, and therefore you may be ultimately responsible for paying out of pocket.

______________________________________________ _______________________
Client/Parent/Guardian Signature Date

Client Name ________________________________