Know Your Insurance Policy Benefits: Behavior/ABA Therapy!

Call your insurance company, ask them the following questions, complete the form and return.
Call reference number:_____ Date: _____

Policy Holder's Name: _____ Policy Holder's Date of Birth: _____

Client's Name: _____ Client's Date of Birth: _____

Insurance Co: _____ Plan Name/Program Name: _____

Insured's ID#: _____ Policy Group #:_____

1. ELIGIBILITY & DEDUCTIBLE: For what period is the client eligible: a calendar year, fiscal year, a year from starting services, or other? Date range: _____
   A. Is there a deductible that needs to be met prior to utilizing your benefits? **Yes or No**
      i. *If yes,* how much is the deductible? Individual $_____ & Family $_____
      ii. Has it been met? **Yes/No**→*If no*, what amount is applied to deductible? $_____
2. PROCEDURE CODE FOR SERVICE(S): Are the following CPT codes covered: 97151-97155, or H2019

If no, consider other payment options: scholarships/grants, Care Credit, Ohio Department of Education – school choice scholarship programs, Help Me Grow, County Board of DD, Family First Council (subsection of county), or private pay.

3. DIAGNOSIS CODE (S): Get the code(s) from your doctor/medical report. If your child has multiple diagnoses, then ask for other ICD-10 codes. Usually Autism is the only diagnosis where ABA is covered.
   A. Diagnosis name: __Autism_____, ICD-10 code: __F84.0___, Covered: **Yes or No**
   B. Is the combination of CPT and ICD-10 code(s) valid, eligible and billable? **Yes or No**

4. PLACE OF SERVICE: Does it matter where services are provided? **Yes or No**
   A. *If yes*, ask if each Place of Service Code is covered:
      a. #11 (in office) **Yes or No**, #12 (in home) **Yes or No**
      b. Are there different coverage rates for facility and non-facility service? **Yes/No**
         i. *If yes,* what are the different rates: Facility$_____; Non-facility$_____

   B. Does a "Prior Authorization/Precertification/Predetermination" need to be done prior to starting services? **Yes or No**
      a. *If yes*, what is the procedure?_____

5. QUANTITY AND RATES: Is there a limited number of sessions covered per year? **Yes or No**
   A. *If yes,* how many? _____ → Is this a hard cap? **Yes or No**
      a. *If no,* what is the procedure to request more services? _____

   B. What is the family's financial responsibility? $_____ copay, or _____% coinsurance
   C. Is there an "out of pocket maximum"? **Yes or No**
      a. *If yes*, how much per individual $_____ & family $_____.
      b. Then, what is the family's responsibility change to? $_____ per visit/unit, or _____%
      c. How much of the out of pocket maximum has been met: $_____