Hamzavi Psychiatry and Wellness Center PLLC
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INSURANCE BENEFIT VERIFICATION FORM
(if applicable)

*****This page is for your information. It does not need to be returned.***

Hamzavi Psychiatry & Wellness Center (HPWC) only participates with Blue Cross Blue Shield PPO, Blue Care Network, Aetna PPO, and Priority Health Insurance. Patients using one of these plans are responsible for inquiring about their own mental health benefits. Please use the Insurance Verification form below to assist in determining your mental health benefits.

Helpful Information:
Deductible*: Deductible is the amount you pay for covered health care services before your* ***insurance*** *plan starts to pay. How it works: You will pay 100% of eligible health care expenses until the bills total your contracted deductible amount. After you pay your* ***deductible****, you usually pay only a copayment or coinsurance for covered services. Your* ***insurance*** *company pays the rest.*

Coinsurance*: Coinsurance is your share of the costs of a health care service. It's usually figured as a percentage of the amount allowed to be charged for services. You start paying coinsurance after you've paid your plan's deductible. **Please note, once we receive payment from your insurance, the copay/coinsurance amount may need to be adjusted.*

Copayment*: A copay is a fixed amount you pay for a health care service, usually when you receive the service. The amount can vary by the type of service. How it works: Your plan determines what your copay is for different types of services, and when you have one. You may have a copay before you've finished paying toward your deductible. You may also have a copay after you pay your deductible, and when you owe coinsurance. **Please note, once we receive payment from your insurance, the copay/coinsurance amount may need to be adjusted.*

Insurance Benefit Verification Information

Call the toll free number on the back of your insurance card. Ask for your "Outpatient Mental Health Benefits" or "Behavioral Health Benefits".

Date & time of your call: _____ *Person's name with whom you spoke:* _____

*Deductible: In-Network: _____ Out-of-Network: _____

*Co-pay: In-Network: _____ Out-of-Network: _____

*Maximum number of sessions/dollar amount per year: _____ Per lifetime: _____

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