

Middleton Counseling

Middleton Office: 22480 Duff Ln., Middleton, ID 83644

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Phone: (208) 965-4502

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MIDDLETON COUNSELING – INSURANCE GUIDE – 2022

It's important to me that neither you or I are caught off guard concerning money matters and paying our fees. In order for us to bill your insurance, you are required to independently look into and understand your insurance coverage, coinsurance, and co-pays in order for my billing office to submit your claims.

→ If you provide this information below, our office will submit claims on your behalf. ←

A: If possible, fill this out BEFORE you call your insurance company.

Today's Date:

Your Name:

Your Date of Birth:

Primary Insurance:

ID Number:

Plan Number (if shown):

Group Number:

Subscriber Name:

Subscriber Date of Birth:

Subscriber Phone Number:

Subscriber Address (if different from your address):

Insurance Company CUSTOMER PHONE Number:

Insurance Company PROVIDER PHONE Number:

B: Call your insurance company.

1. Make the call. On the automated prompt indicate that you need to be connected to Customer Service.
2. "I would like to verify my eligibility and benefits for Outpatient Mental Health Services."
3. "Before we start, can you please confirm that **KIM A NELSON, LCPC** is an IN-NETWORK PROVIDER?"

MIDDLETON COUNSELING
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Kim A Nelson, LCPC-6361
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Middleton Counseling
Group NPI 1457867962

Yes, Middleton Counseling is an In-Network Provider. Proceed to 4.

If not in network, then find out if you have any OUT-OF-NETWORK benefits and what they are. That will help you determine if you want to find a different provider in network.

4. "What is the address my claims should be sent to?"

5. "What is the Electronic Payor Number if my claims are sent electronically?" Number: _____

6. "Do I need a Prior-Authorization for Out-Patient Mental Health visits?"

No **Yes**

7. "Is there a limit to the number of visits I'm allowed?"

No **Yes, # _____**

8. "Do I have a deductible to meet before my Out-Patient Mental Health Services are covered?"

No **Yes: Amount \$_____**

9. "Do I have a Co-Pay for each Out-Patient Mental Health Services visit?"

No **Yes: Amount \$_____**

10. "Do I have any Co-Insurance for Out-Patient Mental Health Services visits?"

No **Yes: Amount \$_____**

11. What is the Name of Representative you are speaking to?

Name: _____

12. May I please have a Call Reference Number?

Number: _____