THE CARRUTH CENTER
AT THE PARISH SCHOOL

DETERMINING YOUR INSURANCE COVERAGE

Please contact your insurance company and/or utilize your Human Resources representative to determine the following items about your policy's benefits and stipulations. All items will pertain to OUT OF NETWORK COVERAGE. When you call, document all information for your records & start a binder/folder to organize your efforts (i.e. for appeals/review of future claims).

Date of Call: _____ Time of Call: _____ Employee: _____

Call Reference Number or Action Number (usually given at end): _____

TERMS OF YOUR POLICY OVERALL

What is your policy's year/term-length (i.e. Effective Date Jan 1st – Dec 31st):_____

What is your Out of Network Deductible: $_____

How much of your Deductible have you met to date: $_____

What is your Out of Network Maximum Out of Pocket/Ceiling (once this amount is reached it may change the level of your coverage): $_____

Does the policy allow for the expenses of the Fourth Quarter of the fiscal year of the policy to be rolled over or counted towards the deductible of the new year? _____

Is Pre-Authorization or a Prescription needed prior to the start of services? _____

IF YES, What documentation is needed for Pre Authorization to take place?

- Initial Evaluation _____
- Dr's Prescription _____
- Call from Clinic _____
- Other _____

TERMS OF THE POLICY FOR SERVICES

Does the policy allow for the consideration of claims utilizing the code for Group Speech Therapy – Coded as 92508? _____

What it the Coverage for 92508?

_____% of fees - typically they state "Of what is Reasonable & Customary"

Can they quote what is considered Reasonable & Customary $_____ per hour or unit
(They may ask for the Clinic's Postal/Zip code to reference 77043)

What will the coverage be when the Out of Pocket Maximum is hit: _____%

Are there any limitations or exclusions noted for the terms of receiving Group Speech Therapy – Here are the major examples we see at the clinic:

- DESIGNATED SESSIONS PER YEAR: _____
  - If yes, ask who/where do you send letters to request a "Gap Extension" for consideration of further services: _____
    _____

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- AGE OF ONSET: _____
- MEDICALLY NECESSARY: _____
  _____
- OTHER: _____
  _____
- Are there any limitations of benefits for specific Diagnostic Codes/Disorders? For example, IF "**A CHILD"** (do not reference your child – leave it open) has the diagnostic code of _____ would there be any exclusion or denial of coverage? Select the following as pertains to your interests.

(The DX CODE chart is used for informational purposes and may not reflect actual DX CODES)

DX CODE	DESCRIPTION	YES	NO
F80.2	Mixed Receptive & Expressive Lang Disorder		
F80.1	Expressive Language Disorder		
F80.0	Phonological Disorder		
R48.2	Apraxia		
F84.8	Other Pervasive Developmental Disorder		
F84.0	Autism		
F41.9	Anxiety Disorder, Unspecified		
F94.0	Selective Mutism		
F90.9	ADHD – Not Otherwise Specified		
F82	Specific Developmental Disorder of Motor Function		
R47.89	Other Speech Disturbances		

DETERMINING ELIGIBILITY FOR OTHER SERVICES:
Please feel free to use this format to determine coverage for other services provided within the clinic:

TREATMENT CODE	DESCRIPTION	YES	NO
92506	Speech and Language Evaluation		
92507	Individual Speech and Language Therapy		
97003	Occupational Therapy Evaluation		
97530 & 97112	Therapeutic Activities & Neuromuscular Re-Education - OT		
90801	Intake/Clinical Interview – Mental Health Professional		
90806	Individual Play Therapy – Mental Health Professional		
90846 &90847	Family Therapy without Child & Fam w/ Child – Mental Health		
90853	Group Play Therapy – Mental Health Professional		
90882	Home Consultation – Mental Health Professional		
96110	Informal Consultation – Mental Health Prof (admission's consult)		
96101	Psychological Evaluation		
96118	Neuropsychological Evaluation		