Get Reimbursed for an Out-of-Network Therapist

Guide to insurance for mental health care.

Where to Start

When you pay your therapist directly, you may have the option to file a claim with your insurance company so they pay some of your costs. Ask your therapist how they handle these situations. Will they file claims for you? If not, you'll need to file the claim with your insurance company.

What Is a Superbill?

To file a claim with your insurance company, **you will need a superbill** — kind of like an invoice — from your therapist that lists all the charges you paid. A superbill should include:

- Therapist's name + address
- Therapist's EIN/tax ID number
- Therapist's NPI number + license number
- Your name + date of birth
- Your diagnosis codes (usually starting with F)

Each charge or session should be listed individually on your superbill. Every line item should include:

- Treatment code (Five-digit number that starts with 9)
- Treatment description
- Office location code
- Amount charged per session

How to Fill Out a Claim Form

Every insurance company has a different way to file claims. Some require a mailed paper claim form, others now have an online system. No matter how you file, always attach a copy of your superbill . Here's generally what a claim form looks like:

Member Claim Form

Not to be used for Medical, Pharmacy or Dental claims

ENROLLEE INFORMATION: *Policy holder complete this section* — Fill out about who holds the policy

A1. EMPLOYEE'S NAME (Last Name)	(First Name)	(M.I.)	A2. GENDER	B. DATE OF BIRTH (MM DD YYYY)
Lopez	Jane	C.	☐ M ☒ F	05 05 1985

C. EMPLOYEE'S MAILING ADDRESS (No., Street)	(City)	(State)	(Zip Code)	DAYTIME TELEPHONE #
123 Front Street	Clovis	CA	93613	(101) 867-5309

IS THIS A CHANGE OF ADDRESS? (Note: address must also be changed with Employer) ☐ YES ☒ NO

D. CIGNA ID NUMBER OR EMPLOYEE SOCIAL SECURITY NUMBER (on the front of your CIGNA ID card) — Look for this on your insurance card

E. ACCOUNT NO. (on the front of your CIGNA ID card) — Look for this on your insurance card

F. EMPLOYER NAME: Name of Employer (other insurance forms may not ask this)

G. EMPLOYEE STATUS: ☒ EMPLOYED ☐ RETIRED* ☐ COBRA* ☐ DISABLED*

*EFFECTIVE DATE (Date you started work): 01 01 2020

PATIENT INFORMATION: *Complete only if patient is other than enrollee*

A. PATIENT'S NAME (Last Name)	(First Name)	(M.I.)	B. RELATIONSHIP TO EMPLOYEE	C. DATE OF BIRTH (MM DD YYYY)	D. GENDER
			☐ Spouse ☐ Child ☐ Other		☐ M ☐ F

E. PATIENT'S ADDRESS - IF DIFFERENT THAN EMPLOYEE ADDRESS (No., Street)	(City)	(State)	(Zip Code)

F. AT THE TIME SERVICE WAS PROVIDED WAS THE PATIENT: ☐ EMPLOYED FULL-TIME ☐ STUDENT FULL-TIME ☐ N/A

ACCIDENT/OCCUPATIONAL CLAIM INFORMATION:
Complete only if claim is a result of an accident or occupational (work related) illness/injury — Skip this section if your claim isn't work-related

A. ACCIDENT OR ILLNESS DUE TO EMPLOYMENT?	B. INJURY DUE TO AUTO ACCIDENT?	C. DESCRIPTION OF HOW ACCIDENT OR WORK RELATED ILLNESS/INJURY OCCURRED
☐ YES ☐ NO	☐ YES ☐ NO	

D. DATE OF ACCIDENT OR BEGINNING OF ILLNESS (MM DD YYYY)

E. ARE YOU OR YOUR DEPENDENTS FILING A CLAIM OR LAWSUIT AGAINST A THIRD PARTY INCLUDING AN INSURANCE COMPANY IN ORDER TO RECOVER THE COST OF EXPENSES INCURRED AS A RESULT OF THIS ACCIDENT OR ILLNESS? ☐ YES ☐ NO If yes, Name of Third Party:

FAMILY/OTHER COVERAGE INFORMATION:
This section should be completed if you have additional insurance coverage
Complete only if claim is for a dependent and/or other coverage is in effect

A. SPOUSE EMPLOYED?	IF NO, HAS SPOUSE BEEN EMPLOYED DURING LAST 12 MONTHS?	B. NAME OF SPOUSE (Last Name)	(First Name)	(M.I.)	SPOUSE'S DATE OF BIRTH (MM DD YYYY)
☐ YES ☐ NO	☐ YES ☐ NO				

C. NAME OF SPOUSE'S EMPLOYER	ADDRESS OF SPOUSE'S EMPLOYER (No., Street)	(City)	(State)	(Zip Code)	TELEPHONE #
					( )

D1. IS THE PATIENT COVERED UNDER ANOTHER EMPLOYER GROUP HEALTH INSURANCE PLAN? ☐ YES ☐ NO If yes, provide:

NAME OF HEALTH INSURANCE COMPANY	EFFECTIVE DATE OF COVERAGE (MM DD YYYY)	POLICY NUMBER	TYPE OF PLAN (HMO OR PPO) IF KNOWN

D2. IS THE PATIENT COVERED UNDER MEDICARE? ☐ YES ☐ NO

IF YES TO D1. OR D2. AND THE OTHER INSURANCE IS PRIMARY, ENCLOSE A COPY OF THE EXPLANATION OF BENEFITS (EOB) WITH THIS FORM AND THE ITEMIZED BILL(S).

CERTIFICATION

Any person who knowingly and with intent to defraud any insurance company or other person: (1) files an application for insurance or statement of claim containing any materially false information; or (2) conceals for the purpose of misleading, information concerning any material fact thereto, commits a fraudulent insurance act which is a crime. For residents in the following states, please see the last page of this form: Alaska, Arizona, California, Colorado, District of Columbia, Florida, Kentucky, Maryland, Minnesota, New Jersey, New York, Oregon, Pennsylvania, Tennessee, Texas and Virginia.

I certify that the information supplied is true and correct.

EMPLOYEE'S SIGNATURE: X Sign here to say everything you have included is correct. — DATE (MM DD YYYY): 01 14 2020

PAYMENT INSTRUCTIONS

I authorize payment to be made directly to the healthcare provider(s) indicated on the enclosed bill(s)

EMPLOYEE'S SIGNATURE: X Only sign here if your insurance company is paying your therapist directly (instead of reimbursing you). — DATE (MM DD YYYY)

Please be aware that if the provider of service holds a contract with CIGNA, and its affiliates, payment will always be made to the provider at the contracted rate even if this section is not signed. If the provider is contracted with CIGNA, the provider will be paid by CIGNA at the contracted rate. If you have already paid for services, you should seek reimbursement directly from the provider.

NOTE: The information provided on this form may be disclosed to other persons or entities, including my Plan Sponsor, for the purpose of processing this claim and performing health plan administration.

What your insurance pays for an out-of-network therapist depends on your plan.

Insurance companies all pay differently for out-of-network services. Ask your insurance company to clarify how it will reimburse your claims so you know what to expect.