Reembolsos para terapia fuera de su cobertura

Guía del seguro para tratamiento de salud mental

Dónde empezar

Cuando usted paga a su terapeuta directamente, usted puede tener la opción de presentar una reclamación con su compañía de seguros para que paguen algunos de sus costos. Pregúntale a tu terapeuta cómo manejan estas situaciones. ¿Presentarán reclamos por usted? Si no es así, usted tendrá que presentar la reclamación ante su compañía de seguros.

¿Qué es un Superbill?

Para presentar una reclamación necesitará un **Superbill** – similar a un recibo de venta- de su terapeuta que contiene todos los cargos que pagó. Un recibo Superbill debe incluir:

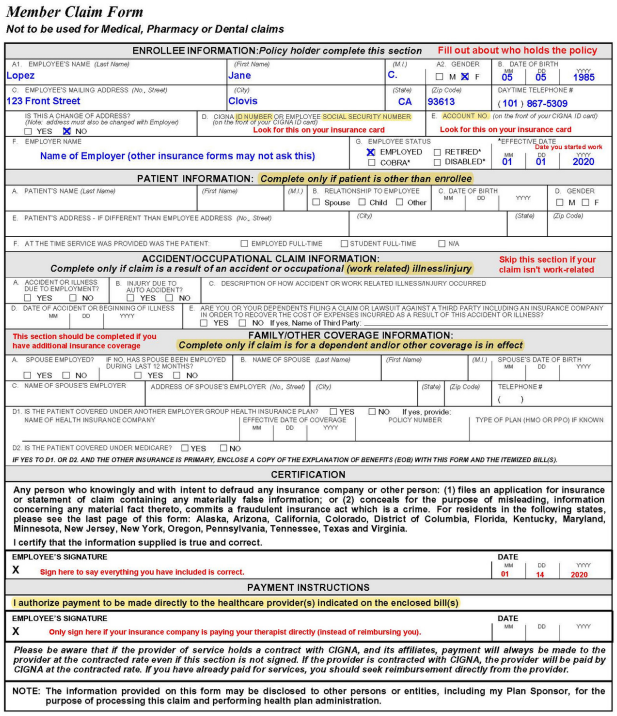
- Nombre del terapeuta + domicilio
- Número de identificación de EIN/impuesto del terapeuta
- Número NPI del terapeuta + número de licencia
- Tu nombre + fecha de nacimiento
- Códigos de diagnóstico (generalmente empiezan con la letra F)

Cada cargo o sesión debe aparecer individualmente en su Superbill. Cada línea de pedido debe incluir:

- Código de tratamiento (número de cinco dígitos que comienza con 9)
- Descripción del tratamiento
- Código de ubicación de la oficina
- Precio de sesión

Cómo llenar un formulario de reclamación

Cada compañía tiene una forma diferente. Algunos requieren que mande su reclamo por correo, otros tienen un formulario por internet. Cuando lo mande, siempre adjunte una copia de su Superbill. Por lo general, un formulario de reclamación contiene lo siguiente:



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): Lopez	(First Name): Jane	(M.I.): C.	A2. GENDER: ☐ M ☒ F	B. DATE OF BIRTH (MM DD YYYY): 05 05 1985
C. EMPLOYEE'S MAILING ADDRESS (No., Street): 123 Front Street	(City): Clovis	(State): CA	(Zip Code): 93613	DAYTIME TELEPHONE #: (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): MM 01 DD 01 YYYY 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: ☐ Spouse ☐ Child ☐ Other	C. DATE OF BIRTH (MM DD YYYY)

D. GENDER: ☐ 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? ☐ YES ☐ NO

B. INJURY DUE TO AUTO ACCIDENT? ☐ YES ☐ NO

C. DESCRIPTION OF HOW ACCIDENT OR WORK RELATED ILLNESS/INJURY OCCURRED

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:

This section should be completed if you have additional insurance coverage

FAMILY/OTHER COVERAGE INFORMATION:
Complete only if claim is for a dependent and/or other coverage is in effect

A. SPOUSE EMPLOYED? ☐ YES ☐ NO — IF NO, HAS SPOUSE BEEN EMPLOYED DURING LAST 12 MONTHS? ☐ YES ☐ NO

B. NAME OF SPOUSE (Last Name) (First Name) (M.I.) — SPOUSE'S DATE OF BIRTH (MM DD YYYY)

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.

Lo que su seguro paga por un terapeuta fuera de cobertura depende de su plan

Todas las compañías de seguros pagan de manera diferente por los servicios fuera de la cobertura. Pídale a su compañía de seguros que aclare cómo reembolsará sus reclamos para estar preparado.