

Filing Out-Of-Network: How To

Step 1: Gather Information

Call the customer service number on the back of your insurance card. If you do not have a card, go to your provider's website and there should be a list of contact numbers. Be prepared to give them the following information:

Patient Information:

- Subscriber's Member ID
- Subscriber's full name
- Subscriber's date of birth

Provider Information:

- Provider's name, phone number, and address
 - o Dr. Deborah L. Kerr, Ph.D.
 - o 205.235.1277
 - o 1731 Whitener Street, Cape Girardeau, MO 63701
- Provider's NPI Number
 - o Dr. Deborah L. Kerr, Ph.D. - 1952706095

Step 2: Call Insurance Provider

Call your insurance company and choose the option that indicates that you are the "card holder" or "member". Please note that you are calling about "Benefits and Eligibility". In order to save time, if it's a voice operated system, you can repeat the word "Representative", and get someone a bit quicker. Or, you could try hitting "0" over and over in an attempt to get a human on the line, as well. Once you get a representative, inform them that you are calling to verify "**Out-Of-Network Benefits**". Also specify that it is for "**Mental Health out-patient office visits**".

Deductibles

The representative may inform you that you must meet a deductible before any out-of-network benefits can be used. Ask them what your deductible is (or you may already know), and how much has been met. Ask if it's based on a calendar year, or on a renewal-date basis. Then you will know how much longer you have to meet your deductible. Sometimes, out-of-network claims will go towards your deductible, so you can ask about that too.

Copays/Percentages

Your out-of-network benefits may reimburse you for all, or some, of your costs. This may depend upon your copay (a set amount paid for all visits), or a percentage that is applied to the visit cost. By using the chart below, you can ask the representative how much they will reimburse you based on these CPT codes:

Individual Psychotherapy Visits	Reimbursement Amount	Family and Group Psychotherapy Visits	Reimbursement Amount
90791: Initial Appointment		90846: Family w/o patient	
90837: 60 minute apt.		90847: Family w/ patient	
		90853: Group therapy apt.	

Psychological and Neuropsychological Assessment by psychologist (per hour)	Reimbursement Amount
96101: Psychological testing, interpretation and reporting (per hour)	
96116: Neurobehavioral Status Exam (per hour)	
96118: Neuropsychological testing, interpretation and reporting (per hour)	

Step 3: Documentation Needs

Ask what documentation is needed in order to file the claims. Most of the time you will need: Date of Service, CPT Code (in chart above), and all Diagnosis Codes in order to file the claim. You may use the fillable PDF claim form found on my website, or you can ask them to send you some claim forms. Be sure to get the correct mailing address where the claims need to be sent. You may need my tax ID number which is: 492-94-3264 and/OR my EIN number 38-4158108. Note that while Great Oak or UABHS may still have me listed as credentialed with in network insurance panels, I am not as of April 21, 2023.

Step 4: Fill out Claim Form and Send Off

Fill out your claim form, and if you're using the fillable PDF version you can save it to your desktop and edit it for future visits. You can reference my sample 1500 form, as well as read through the "Filling out a 1500 Form" document. Make sure to include all documentation requested by your insurance provider, and mail it off.

Filling out a 1500 Form (if requested by your insurance provider):

Use the invoice provided by Mountain Brook Wellness to help you gather the information needed. An invoice is sometimes called a “superbill”.

To see an example of a filled out 1500 form and the invoice that went with it, return to the Forms and Resources page and go to “Filling out a 1500 Form-Example”.

*NOTE: Again, most insurance providers have their own form version. Make sure to ask about this first on your initial phone call. The 1500 form here is a generic Federal form if they do not.

Step 1: Fill out as much of the requested demographic/insurance information as you can, in the top boxes 1-13, of the 1500 form.

Step 2: Fill out the rest of the form using information gathered from your invoice.

Box 21: Fill out the diagnosis code which can be found on your invoice (ex.F43.20)

Box 24:a. Be sure and put the correct date of service, enter it in twice, in the “From”, “To” spots.

- b. Enter in the number 11 as the place of service (unless concierge)
- c. Skip it
- d. Use your invoice to find your particular CPT code, it’s the number listed under the column “Details”
- e. Most patients will only have one diagnosis code, so you just type 1, to show them which code to reference from Box 21. If, however, you have multiple codes, you can list them out like 1,2,3....etc.
- f. Fill out the cost of the appointment (this is the amount you paid)
- g. Put in a number 1
- h. Skip it
- i. Skip it
- j. Type in your providers NPI number, in my example, it’s: 1952706095. You can find this on your invoice, or in the “Filing Out-Of-Network: How To”

Box 25: Enter in my Tax ID number: 492-94-3264 and/OR EIN number:

(same as before)

Boxes 28, 29: Enter in the total cost (how much you **paid**)

Boxes 32 & 33: Enter in the information just as it is on the sample 1500 form

Boxes 32a & 33a: Enter in my NPI number (same as before)

Step 3: Submit your form, and your invoice, to the address provided to you by your insurance company. *You’re all done! If you need my signature on the form, or run into any other issues, do not hesitate to contact me!*



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

CARRIER
PATIENT AND INSURED INFORMATION

PICA <input type="checkbox"/>		PICA <input type="checkbox"/>	
1. MEDICARE <input type="checkbox"/> (Medicare#) MEDICAID <input type="checkbox"/> (Medicaid#) TRICARE <input type="checkbox"/> (ID#/DoD#) CHAMPVA <input type="checkbox"/> (Member ID#) GROUP HEALTH PLAN <input type="checkbox"/> (ID#) FECA BLK LUNG <input type="checkbox"/> (ID#) OTHER <input type="checkbox"/> (ID#)		1a. INSURED'S I.D. NUMBER (For Program in Item 1)	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)		3. PATIENT'S BIRTH DATE MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>	
5. PATIENT'S ADDRESS (No., Street)		6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>	
CITY STATE		7. INSURED'S ADDRESS (No., Street)	
ZIP CODE TELEPHONE (Include Area Code) ()		CITY STATE	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		8. RESERVED FOR NUCC USE	
a. OTHER INSURED'S POLICY OR GROUP NUMBER		10. IS PATIENT'S CONDITION RELATED TO:	
b. RESERVED FOR NUCC USE		a. EMPLOYMENT? (Current or Previous) YES <input type="checkbox"/> NO <input type="checkbox"/>	
c. RESERVED FOR NUCC USE		b. AUTO ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/> PLACE (State) _____	
d. INSURANCE PLAN NAME OR PROGRAM NAME		c. OTHER ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/>	
10d. CLAIM CODES (Designated by NUCC)		11. INSURED'S POLICY GROUP OR FECA NUMBER	
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.		a. INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>	
SIGNED _____ DATE _____		b. OTHER CLAIM ID (Designated by NUCC)	
		c. INSURANCE PLAN NAME OR PROGRAM NAME	
		d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES <input type="checkbox"/> NO <input type="checkbox"/> If yes, complete items 9, 9a, and 9d.	
		13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.	
		SIGNED _____	

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL		15. OTHER DATE MM DD YY QUAL		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE		17a. _____		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY	
		17b. NPI _____			
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		20. OUTSIDE LAB? YES <input type="checkbox"/> NO <input type="checkbox"/> \$ CHARGES _____		22. RESUBMISSION CODE ORIGINAL REF. NO.	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) A. _____ B. _____ C. _____ D. _____ E. _____ F. _____ G. _____ H. _____ I. _____ J. _____ K. _____ L. _____ ICD Ind. _____		23. PRIOR AUTHORIZATION NUMBER			

	24. A. DATE(S) OF SERVICE		B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)		E. DIAGNOSIS POINTER	F. \$ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL	J. RENDERING PROVIDER ID. #
	From MM DD	To YY			CPT/HCPCS	MODIFIER						
1												
2												
3												
4												
5												
6												

25. FEDERAL TAX I.D. NUMBER SSN EIN <input type="checkbox"/>		26. PATIENT'S ACCOUNT NO.		27. ACCEPT ASSIGNMENT? (For govt claims, see back) YES <input type="checkbox"/> NO <input type="checkbox"/>		28. TOTAL CHARGE \$		29. AMOUNT PAID \$		30. Rsvd. for NUCC Use	
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)		32. SERVICE FACILITY LOCATION INFORMATION		33. BILLING PROVIDER INFO & PH # ()		a. NPI		b. NPI			
SIGNED _____ DATE _____		a. NPI		b. NPI		a. NPI		b. NPI			

PHYSICIAN OR SUPPLIER INFORMATION

BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAMS.

NOTICE: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.

REFERS TO GOVERNMENT PROGRAMS ONLY

MEDICARE AND CHAMPUS PAYMENTS: A patient's signature requests that payment be made and authorizes release of any information necessary to process the claim and certifies that the information provided in Blocks 1 through 12 is true, accurate and complete. In the case of a Medicare claim, the patient's signature authorizes any entity to release to Medicare medical and nonmedical information, including employment status, and whether the person has employer group health insurance, liability, no-fault, worker's compensation or other insurance which is responsible to pay for the services for which the Medicare claim is made. See 42 CFR 411.24(a). If item 9 is completed, the patient's signature authorizes release of the information to the health plan or agency shown. In Medicare assigned or CHAMPUS participation cases, the physician agrees to accept the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary as the full charge, and the patient is responsible only for the deductible, coinsurance and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary if this is less than the charge submitted. CHAMPUS is not a health insurance program but makes payment for health benefits provided through certain affiliations with the Uniformed Services. Information on the patient's sponsor should be provided in those items captioned in "Insured"; i.e., items 1a, 4, 6, 7, 9, and 11.

BLACK LUNG AND FECA CLAIMS

The provider agrees to accept the amount paid by the Government as payment in full. See Black Lung and FECA instructions regarding required procedure and diagnosis coding systems.

SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDICARE, CHAMPUS, FECA AND BLACK LUNG)

I certify that the services shown on this form were medically indicated and necessary for the health of the patient and were personally furnished by me or were furnished incident to my professional service by my employee under my immediate personal supervision, except as otherwise expressly permitted by Medicare or CHAMPUS regulations.

For services to be considered as "incident" to a physician's professional service, 1) they must be rendered under the physician's immediate personal supervision by his/her employee, 2) they must be an integral, although incidental part of a covered physician's service, 3) they must be of kinds commonly furnished in physician's offices, and 4) the services of nonphysicians must be included on the physician's bills.

For CHAMPUS claims, I further certify that I (or any employee) who rendered services am not an active duty member of the Uniformed Services or a civilian employee of the United States Government or a contract employee of the United States Government, either civilian or military (refer to 5 USC 5536). For Black-Lung claims, I further certify that the services performed were for a Black Lung-related disorder.

No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (42 CFR 424.32).

NOTICE: Any one who misrepresents or falsifies essential information to receive payment from Federal funds requested by this form may upon conviction be subject to fine and imprisonment under applicable Federal laws.

NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF MEDICARE, CHAMPUS, FECA, AND BLACK LUNG INFORMATION (PRIVACY ACT STATEMENT)

We are authorized by CMS, CHAMPUS and OWCP to ask you for information needed in the administration of the Medicare, CHAMPUS, FECA, and Black Lung programs. Authority to collect information is in section 205(a), 1862, 1872 and 1874 of the Social Security Act as amended, 42 CFR 411.24(a) and 424.5(a) (6), and 44 USC 3101;41 CFR 101 et seq and 10 USC 1079 and 1086; 5 USC 8101 et seq; and 30 USC 901 et seq; 38 USC 613; E.O. 9397.

The information we obtain to complete claims under these programs is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are covered by these programs and to insure that proper payment is made.

The information may also be given to other providers of services, carriers, intermediaries, medical review boards, health plans, and other organizations or Federal agencies, for the effective administration of Federal provisions that require other third parties payers to pay primary to Federal program, and as otherwise necessary to administer these programs. For example, it may be necessary to disclose information about the benefits you have used to a hospital or doctor. Additional disclosures are made through routine uses for information contained in systems of records.

FOR MEDICARE CLAIMS: See the notice modifying system No. 09-70-0501, titled, 'Carrier Medicare Claims Record,' published in the Federal Register, Vol. 55 No. 177, page 37549, Wed. Sept. 12, 1990, or as updated and republished.

FOR OWCP CLAIMS: Department of Labor, Privacy Act of 1974, "Republication of Notice of Systems of Records," Federal Register Vol. 55 No. 40, Wed Feb. 28, 1990, See ESA-5, ESA-6, ESA-12, ESA-13, ESA-30, or as updated and republished.

FOR CHAMPUS CLAIMS: PRINCIPLE PURPOSE(S): To evaluate eligibility for medical care provided by civilian sources and to issue payment upon establishment of eligibility and determination that the services/supplies received are authorized by law.

ROUTINE USE(S): Information from claims and related documents may be given to the Dept. of Veterans Affairs, the Dept. of Health and Human Services and/or the Dept. of Transportation consistent with their statutory administrative responsibilities under CHAMPUS/CHAMPVA; to the Dept. of Justice for representation of the Secretary of Defense in civil actions; to the Internal Revenue Service, private collection agencies, and consumer reporting agencies in connection with recoupment claims; and to Congressional Offices in response to inquiries made at the request of the person to whom a record pertains. Appropriate disclosures may be made to other federal, state, local, foreign government agencies, private business entities, and individual providers of care, on matters relating to entitlement, claims adjudication, fraud, program abuse, utilization review, quality assurance, peer review, program integrity, third-party liability, coordination of benefits, and civil and criminal litigation related to the operation of CHAMPUS.

DISCLOSURES: Voluntary; however, failure to provide information will result in delay in payment or may result in denial of claim. With the one exception discussed below, there are no penalties under these programs for refusing to supply information. However, failure to furnish information regarding the medical services rendered or the amount charged would prevent payment of claims under these programs. Failure to furnish any other information, such as name or claim number, would delay payment of the claim. Failure to provide medical information under FECA could be deemed an obstruction.

It is mandatory that you tell us if you know that another party is responsible for paying for your treatment. Section 1128B of the Social Security Act and 31 USC 3801-3812 provide penalties for withholding this information.

You should be aware that P.L. 100-503, the "Computer Matching and Privacy Protection Act of 1988", permits the government to verify information by way of computer matches.

MEDICAID PAYMENTS (PROVIDER CERTIFICATION)

I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the State's Title XIX plan and to furnish information regarding any payments claimed for providing such services as the State Agency or Dept. of Health and Human Services may request.

I further agree to accept, as payment in full, the amount paid by the Medicaid program for those claims submitted for payment under that program, with the exception of authorized deductible, coinsurance, co-payment or similar cost-sharing charge.

SIGNATURE OF PHYSICIAN (OR SUPPLIER): I certify that the services listed above were medically indicated and necessary to the health of this patient and were personally furnished by me or my employee under my personal direction.

NOTICE: This is to certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0999. The time required to complete this information collection is estimated to average 10 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, Attn: PRA Reports Clearance Officer, 7500 Security Boulevard, Baltimore, Maryland 21244-1850. T his address is for comments and/or suggestions only. DO NOT MAIL COMPLETED CLAIM FORMS TO THIS ADDRESS.

8 REASONS TO SEE AN OUT-OF-NETWORK THERAPIST

- 1 You're looking for a therapist with a unique skill set
- 2 You have a high deductible plan
- 3 You have good out-of-network benefits
- 4 You want highly personalized services
- 5 You want to combine medication management with talk therapy
- 6 You don't wish to use insurance benefits
- 7 You don't want to wait to start therapy
- 8 You found a great match!