

# **Insurance Cheat Sheet**

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There are two ways to file insurance – in-network and out-of-network.

Using an out-of-network provider often times out-weighs the benefits of an in-network provider:

- When using in-network insurance the provider must document a medical diagnosis sometimes including detailed information about your session notes before they approve sessions. With out-of-network providers they generally do not have these stipulations.
- Insurance providers spend a significant amount of energy on saving money and a large amount of a provider's fees is taken by the insurance companies. When using an out-of-network provider, your fees is paid directly to the local office rather than the larger corporate office.

Please refer to the following steps to fully understand your out-of-network benefits.

**1. Call the toll-free number on the back of your insurance card designated for “Consumers” or “Customers”. Follow the prompts to be connected with a customer service representative, which can advise you of your plan information.**

**2. Ask the customer service representative the following questions:**

What are my out-of-network mental health benefits?	
What is my yearly deductible in my out-of network plan?	
How many sessions am I allowed per year in my out-of-network plan?	
Is pre-approval required to see an out-of network provider?	
Where do I mail my claims for services rendered?	
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What information will you need in order to get my claim reimbursed?	

**3. Fill out appropriate forms to submit with your receipt (if required).**

**4. Mail claim form and/or receipt to your insurance provider and receive your % reimbursement within a matter of weeks.**