CARE AND COUNSELING CENTER OF GEORGIA

INSURANCE PRE-CERTIFICATION AND AUTHORIZATION

Date of call: ________________ Therapist: _____________________ Center: ________

Insurance company: ____

Insurance telephone number ____

Name of Ins. Rep. spoken with ____

Client's name: ___________________________________ Date of Birth: _____________

Insured ID#: ___________ Date of Birth: _____________ Group ID#: _____________

Is provider In _____ or Out ______ of network?

What is coverage for out-of-network providers? __________________________________

Insurance policy effective date? ____

Is there a deductible? ______ How much of deductible has been met? _______________

How many visits per year? ___________________

Authorization needed? Yes _____ No _____ *If yes, therapist must call.*

What is authorization #? ______________________________________

Treatment plan or reauthorization needed? ______ When? _________________________

Verify **Mental Health** claims address: ____

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Additional questions?

Contact CCCG Billing at (404) 636-1457, Ext. 408/ Linda Smith