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Out of Network Benefits Worksheet

Below are questions to ask your health insurance provider regarding reimbursement for out of network mental health benefits:

1. Do I have out of network benefits for mental health services? If not, can I obtain out of network benefits? Do I need pre-authorization or referral from a primary care physician to use my out of network benefits?

   Note: Most plans that offer out of network coverage will reimburse a percentage of their "reasonable and customary" (R&C) fee, after an out of pocket deductible is met.

2. Do I have a deductible?

   Note: This is the amount your insurance provider expects you to pay before they will start reimbursing you. Most plans have a yearly deductible.

3. What is the reasonable and customary fee for the following services in the 10019 zip code, and the percent reimbursement?

   The following table may be useful:

CPT Code & Description	R&C	% Reimbursable (after deducible)
90792 (initial psychiatric evaluation with medical services)		
99213 (level 3 evaluation and management)		
99214 (level 4 evaluation and management)		
90833 (30 minute psychotherapy add-on)		
90836 (45 minute psychotherapy add-on)		
90838 (60 minute psychotherapy add-on)		

4. When does my coverage begin and end?

5. How many therapy sessions per year are covered?

6. Does my plan have a maximum out of network annual limit?