



## **INSURANCE FACT SHEET**

### **To ensure prompt correspondence from insurance companies, clients should:**

- Call their insurance company to setup precertification or preauthorization for services
- Inform the Billing and Insurance Coordinator on the status of claims, both problems and successes, in a timely manner
- Keep up with the number of visits their insurance authorizes

### **3-C Family Services is out-of-network, but as a courtesy to our clients we will:**

- Correctly input the Client's insurance information into our system
- Provide a **one-time** courtesy file to the primary insurance company within 3 business days per date of service

### **Please note:**

- If you are 18 years or older and under a Guardian's insurance policy, 3-C Family Services reserves the right to speak with the Guardian/ Policy Holder in regards to any insurance issues.
- 3-C Family Services will only file to the primary insurance company

### **Resources:**

- 1-800 number on the back of your insurance card
- Billing and Insurance Coordinator: Ashley Lewis
  - [lewis@3cfs.com](mailto:lewis@3cfs.com)
  - 919.677.0101 ext. 513
- Commonly used procedure (CPT) codes:
  - 90801: Initial Intake Evaluation
  - 90806: Individual or Family Therapy Session, lasting 45-60 minutes
  - 90805: Medication Management, lasting 20-30 minutes
  - 90807: Medication Management, lasting 45-60 minutes
  - 90853: Group Therapy

*Per the Health Insurance Portability and Accountability Act (HIPAA) this information is strictly confidential.*



**INSURANCE INFORMATION FORM**

*All fields are required to be completed on this form*

Client Name: \_\_\_\_\_

**POLICY HOLDER'S INFORMATION**

Primary Insurance Company: \_\_\_\_\_

Subscriber/ Policy Holder's Name: \_\_\_\_\_

Client's Relationship to Subscriber/ Policy Holder: \_\_\_\_\_

Subscriber/ Identification Policy #: \_\_\_\_\_

Group # (if applicable): \_\_\_\_\_

Client's Effective Date on the Insurance Policy: \_\_\_\_\_

Policy Holder's Date of Birth: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Policy Holder's Gender:  Male  Female  
MM DD YYYY

Policy Holder's Employer: \_\_\_\_\_

Policy Holder's Social Security Number: \_\_\_\_\_

**Please choose one of the following options:**

- I want 3-C Family Services to assist in filing my insurance claim using "Out of Network" options. I authorize 3-C Family Services to communicate with my insurance provider regarding treatment. I understand that 3-C Family Services will follow HIPAA compliance guidelines regarding confidentiality and only provide the necessary information requested by my insurance provider. **I understand that if I am 18 years or older 3-C Family Services reserves the right to speak with the policy holder/guardian about any insurance issues.**
- I do not want 3-C Family Services' assistance with filing my insurance claim.

**By signing below I acknowledge that I have read and fully understand 3-C Family Services' Insurance Fact Sheet. I understand that my individual insurance policy is a contract between the insurance company and myself, and 3-C Family Services is not a party to that contract. I understand that not all services may be covered by my policy. By presenting for care, I agree that I am responsible for all services and charges, regardless of my insurance status. 3-C Family Services will not alter my claim, change my diagnosis, or report a different service than what was performed in order for my insurance to cover the charge.**

Client's Signature (required for client's 18 years or older) \_\_\_\_\_ Date \_\_\_\_\_

Parent's or Legal Guardian's Signature (required for minor clients 17 years old or younger) \_\_\_\_\_ Date \_\_\_\_\_

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