

Pre-Authorization

Use this form to contact your insurance company and verify coverage.

If you fill in all the blanks, you won't have any surprises about your coverage limits, your deductible status, and your copay. I'll take a photo of your insurance card and driver's license at my office.

Carrier and Plan Name _____

Insured's name _____

ID number _____ Group number _____

Insurance Plan contact number _____

Name of the person you are speaking with _____

Today's date: _____

Confirm you have mental health benefits for CPT codes 90791 and 90837 **YES** / **NO**

Confirm Audio/Visual sessions are covered 90791-95 and 90837-95 **YES** / **NO**

Are services covered with Gregory Kyle Williams as your provider **YES** / **NO**

Annual Deductible \$ _____ Individual \$ _____ Family \$ _____

Deductible met? **YES** / **NO**

Coverage Year begins (date) _____ Copay for office visits \$ _____

Authorization dates (from ____ / ____ /2024 to ____ / ____ /20__)

Do you have HSA or reimbursement from your employer for deductible? Please describe:

Practice Information:

My degree and relevant identifying information which your insurance provider may ask for:

Gregory Kyle Williams LMSW ACSW (some plans list me under Gregory, some Kyle or both)

NPI - 1972752889 (National Provider Identification Number)

LMSW – 6801084481 (my Michigan clinical social worker license number)

ACSW – 884799719 (some plans require my national certification for reimbursement)

Federal Tax ID – 301276038 - Coaching Partnerships, PLC dba "Kyle Williams LMSW ACSW"

Office Information:

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