KYLE WILLIAMS LMSW ACSW
Coaching Partnerships for Personal and Professional Excellence

Insurance Reimbursement Addendum to the Treatment Agreement:

As a practice (Coaching Partnerships, LLC dba "Kyle Williams LMSW ACSW"), I am enrolled in some managed care and traditional insurance plans in an effort to accommodate the related insurance reimbursement needs and requests of some of my clients.

While I am pleased to be able to provide this service to you, it is extremely difficult for me as an individual practitioner to track of all of the individual requirements of the various insurance plans.

Each plan has different stipulations regarding how often services may be rendered and, even more importantly, where those services may be performed. Even within the same insurance company, the plan may differ depending upon what type of contract the insured's employer has negotiated.

Providing quality therapeutic care for my clients is my primary concern. I am willing to provide that care within your insurance contract guidelines, provided you let me know what those guidelines constitute.

It is in your best interest to contact your insurance provider and collect all necessary information for reimbursement. With your cooperation and providing necessary information, you should have no surprises and you should be able to receive all of the benefits offered by your employer and / or insurance provider.

Attached to this document is a form to request all of the information needed for the claim. Please complete all questions! This will save us time and save you a second call to your insurance company!

Unfortunately, if you do not inform me of plan coverage and benefit information, you will not receive the necessary payment from your insurance company. In such cases, you are ultimately financially responsible for full payment to my practice for services rendered.

Please let me know if you have additional questions regarding this policy.

I accept the Insurance Policy addendum to the Treatment Agreement:

Signed ____ Date _______________________
Client or responsible party

Signed ____ Date _______________________
G. Kyle Williams ACSW LMSW

All Information Required for Insurance Submission

(Please do not skip any question on the next two pages! HCFA forms require all of this info!)

Client Information

First Name____________________________ Last Name__________________________

Street Address ____

City ___________________State _____ Zip____________

Primary Telephone ______________________ Client's date of birth _____________________

Claim Information

Circle - Employment Status – please circle employed – **YES / NO / full time / part time**

Primary Insurance ____

Full Mailing Address: ____

Circle - Type of Insurance – Group, HMO, Medicare, Individual

Circle - Your relationship to Insured (self , spouse , child , other)

Insured Information:

Insured's ID Number______________________ Insurance Company_____________________

Group Number (usually lower left corner of your card) _________________________________

Insured's Date of Birth ________________________

Insured's employer ___________________________

Insurance Plan Name _________________________

Do you have an additional health insurance plan? Yes / No

Insured's Name

Last______________________, First__________________________

Insured's Street Address _____________________________________(if different from yours)

City______________________ State_____ ZIP _________________

Insured's date of birth ____

Primary telephone ____

Signature ________________________________Today's Date _______________________

Pre-Authorization:

You must call your insurance company to inquire regarding your insurance coverage for mental heath services. Plans have a wide degree of variation and you are responsible for understanding the limits and benefits your plan offers.

To submit therapy services for medical reimbursement, I must submit a psychiatric diagnosis related to the treatment I provide. If you have questions regarding this issue, please ask!

Plan Coverage – get this information from your insurance provider's customer service telephone number on your card:

Insurance Plan contact number ____

Name of the person you are speaking with _______________________________

Today's date: _______________________________

Confirm that you have “mental health benefits for CPT codes 90791 and 90837” YES / NO

Are services covered with me as your provider YES / NO

Annual Deductible $_____________ Individual $____________ Family $____________

Deductible met? YES / NO

Coverage Year begins (date) ______________ Copay for office visits $______________

Authorization Number (if required) ___________________________ Number of visits ________

Authorization dates (from ____/_____/2015 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 ACSW LMSW (some plans list me under Gregory, some Kyle)
Tax ID - 90-0198689
NPI - 1972752889 (national provider identification number)
LMSW – 6801084481 (my state clinical social worker license)
ACSW – 884799719 (some plans require my national certification for reimbursement)

Office Information:
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