

How to Access and Understand Your Mental Health Benefits and Obtain Referrals

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Mental Health Referral Information Form

Insurance Contact Information:

Mental health referral phone number: _____

Customer Service phone number(s): _____

Substance Abuse referral phone number: _____

Benefit Information:

In-network benefits:

Number of sessions/days: _____

Parity? _____

Deductable: _____

Co-payment: _____

Out-of-network benefits:

Number of sessions/days: _____

Parity? _____

Deductable: _____

Co-payment: _____

Instructions once provider selected:

Authorization needed (when and at what phone#?): _____

Does Primary Care Provider (PCP) need to be notified?: _____

Other instructions: _____

Mental Health Provider/Treatment Facility Referral Information:

Gender preference: _____

Zip Code: _____

Maximum mile radius from Zip Code: 1 5 10 20 30 40 50

Type of provider(s)/facility requested: _____

Specialization(s) preferred: _____

Provider/treatment facility list website address(es): _____

Website instructions: _____

<http://www.ocfboston.org/insurance.html>