Methodist Counseling & Consultation Services
1801 E. Fifth Street, Suite 110
Charlotte, NC 28204-2472
(704) 375-5354
Fax: (703) 375-3069

Insurance Authorization of Benefits

Date:_____

Therapist:_____

Name of Client:
First:_____ Middle_____ Last_____

Phone Number_____ Date of Birth_____

Insurance Company for **Mental Health Benefits**

Name of Insurance Company:_____

Address of Insurance Company:_____

_____

Phone Number of Insurance Company:_____

Primary_____ Secondary_____

Subscriber Name:_____ Date of Birth:_____
Subscriber ID#_____
Group ID#_____
Effective Date_____

Another Health Plan? Yes_____ No_____

Please attach a copy of insurance card (front and back)

I authorize payment of medical benefits to **Methodist Counseling and Consultation Services** (MCCS). **MCCS** will file your claim for you, and re-file if necessary, but will not assume responsibility for collecting on your insurance claim or negotiating settlement on a disputed claim. It is **MCCS** policy that all persons filing insurance must pay per session where their gross family income places them on the adjusted fee scale until the respective insurance company begins making payments. **MCCS** will then make any necessary account adjustments. If your insurance does **not pay** your claim, it will be your responsibility to pay.

Signed_____ Date_____

For Office Use Only

Deductibe:_____Deductible met? Yes_____ No_____
Authorization needed? Yes_____ No_____ Authorization number:_____
Number of sessions authorized_____
DSM-IV number:_____