

**Insurance Benefits/Preauthorization  
Family Counseling Center  
6700 West 44th Ave.  
Wheat Ridge, CO 80033  
Lost and Found, Inc. FEIN 23-7439212**

Please contact your insurance company before we refer you to a staff member so that we can be sure that you have coverage. Any of our therapists can work with out-of-network benefits. In-network benefits are very limited.

Name: \_\_\_\_\_ Date of birth: \_\_\_\_\_

SS#: \_\_\_\_\_

Employer: \_\_\_\_\_

Primary Employee: \_\_\_\_\_

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

Group #: \_\_\_\_\_

Insurance Address: \_\_\_\_\_

\_\_\_\_\_

Fax: \_\_\_\_\_ Email: \_\_\_\_\_

Contact Rep: \_\_\_\_\_

Date of contact: \_\_\_\_\_

Preauthorization number: \_\_\_\_\_

Insurance billing address (often different for mental health than what is on the card): \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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**Benefit Questions**

(To be answered by the Insurance Company Contact Person)

Coverage for:  In-Network Benefits

1. Start date for benefit year (calendar year or other?) \_\_\_\_\_
2. Deductible: \_\_\_\_\_ Insurance pays: \_\_\_\_\_%  
Client pays: \_\_\_\_\_% Copay: \_\_\_\_\_
3. Yearly maximums: \$ \_\_\_\_\_ #of visits \_\_\_\_\_ #times/week: \_\_\_\_\_  
#hours/day: \_\_\_\_\_
4. Has the deductible been met? \_\_\_\_\_ How much remains? \_\_\_\_\_
5. Which types of sessions do you cover?:  individual  couples  family  groups  
 testing  collateral (meeting with family without client present)
6. List any problems/diagnoses that are NOT covered: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
7. Do you require treatment plans?:  Yes  No Updates?:  Yes  No How often: \_\_\_\_\_

Coverage For  Out-of-Network Benefits

(Insurance usually covers less for out of network providers)

1. Deductible: \_\_\_\_\_ Insurance pays: \_\_\_\_\_%  
Client pays: \_\_\_\_\_% Copay: \_\_\_\_\_
2. Yearly maximums: \$: \_\_\_\_\_ #of visits: \_\_\_\_\_ #times/week: \_\_\_\_\_  
#hours/day: \_\_\_\_\_
3. Has the deductible been met? \_\_\_\_\_ How much remains? \_\_\_\_\_

I understand that I am responsible for all fees not covered by my insurance and that a preauthorization from my company is not a guarantee to pay.

\_\_\_\_\_  
Signature/date

(Write other comments/information below)