

CARE AND COUNSELING CENTER OF GEORGIA

INSURANCE PRE-CERTIFICATION AND AUTHORIZATION

Date of call: _____ Therapist: _____ Center #: _____

Insurance company: _____

Insurance telephone number _____

Name of Ins Rep spoken with _____

Client's name: _____ Date of Birth: _____

Insured ID#: _____ Date of Birth: _____ Group #: _____

Is provider in ___ or out ___ of network? What is coverage for out of network providers? _____

Insurance policy effective date? _____

Is there a deductible? ___ How much of deductible has been met? _____

How many visits per year? _____

Authorization needed? Yes ___ No ___ If yes, therapist must call. What is authorization #? _____

Treatment plan or reauthorization needed? ___ When? _____

Verify **Mental Health** claims address: _____

Additional Questions?

Contact CCCG Billing at 404-636-1457 Ext. 215/Linda Smith