

**THE ATTACHMENT AND TRAUMA CENTER OF NEBRASKA
Insurance Authorization/Precertification**

Date: _____ Direct Referral Asked for a Therapist

Therapist: _____ Provider # _____

Client: _____ D.O.B. _____

EAP? _____ yes. If yes, name of EAP _____ # of sessions _____

	Primary Insurance		Secondary Insurance	
	In Network	Out of Network	In Network	Out of Network
Name of Policy Holder				
Social Security Number				
Name of Employer				
Insurance Company Name				
Precertification Phone #				
Member #				
Group #				
Effective Date of Insurance				
Deductible				
Co-Pay				
Benefit %				
Authorization Number				
Dates of Authorization				
# of Sessions Allowed	<input type="checkbox"/> Cal Yr.		<input type="checkbox"/> Cal Yr.	
Covered Credentials MD <input type="checkbox"/> PhD <input type="checkbox"/> LCSW <input type="checkbox"/> LMHP <input type="checkbox"/>				
Provider Representative quoting benefits/authorization:				

- | | |
|-----------------------------------|---|
| _____ 90801 Initial Evaluation | _____ 96101 Psych Testing – 1 hr |
| _____ H0031-H0 IE Non-Physician | _____ 96152 Psych Testing – ½ hr |
| _____ H0002 PTA / Medicaid Only | _____ 80030 Late Cancel / No Show |
| _____ H002-52 PTA Addendum | _____ 99075 Medical Testimony/Court |
| _____ 90804 Ind Psych – 25 min | _____ 99080 Special Reports / Insurance |
| _____ 90806 Ind Psych – 50 min | _____ 90846 Family Psych w/o client |
| _____ 90808 Ind Psych – 75-80 min | _____ 99244 Consultation / Supervision |
| _____ 90847 Family Psych | _____ 99214 Annual Update / PhD/MD |
| _____ 90853 Group Psych | _____ Other: _____ |

EMERGENCY CONTACT

Name/Relationship to client _____
 Address _____ Phone _____
 Primary Care MD/Clinic _____
 Address _____