NUTRITIOUS thoughts

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Nutritional Counseling Insurance Coverage Worksheet

If you will be using your health insurance policy to cover a portion of your Nutritional Counseling, you will need to understand your coverage. The best approach is for you to call your insurance company prior to your first visit so you can plan your budget accordingly. Coverage and plans may vary widely, even amongst the same company. Be prepared to slow down (or stop) the representative on the phone and ask them to explain all of their terminology. We encourage you to document what they say and record their name and reference number they give you at the close of the conversation.

Below is a sample guideline you can follow when calling your insurance company:

1. Check your insurance card for the Customer Service telephone number.
2. Call the Customer Service number and explain to them that you need to verify "Nutritional Counseling in Office Benefits".
3. Is (clinician name) currently an in-network provider for my plan?
4. If not, what are my out of network benefits?
5. Does my policy cover (some of the most common CPT Codes that Nutritious Thoughts uses):
    - Evaluation/Assessment (first appointment) = CPT Code 97802
    - Follow-up Sessions = CPT Code 97803
    - Group Sessions = CPT Code 97804
6. Is pre-certification necessary for any of the CPT codes above?
7. Do I have a deductible for Nutritional Counseling services?
8. If yes, how much is it and how much has been met so far?
9. Is there a copayment for each visit or what is the percentage of coverage?
10. How many Sessions are covered per year and in what month does your policy year begin?
11. Are there any restrictions and/or limitations to my coverage? (Diagnosis codes?)

Here is a list of helpful definitions:

In-Network - Doctors, hospitals, clinics, and other health care providers who have a contract with your insurance carrier to provide services to you at a discount.

Out-of-Network - Services from health care providers who don't have a contract with your plan will usually cost you more than those received from an in-network provider.

Deductible - The amount you pay for eligible services during a benefit period before your plan begins to pay. For example, if your deductible is $1000, your plan won't pay anything until you've met your $1000 deductible for covered health care services subject to the deductible. The deductible may not apply to all services. This means you may be able to pay a copayment rather than the full amount (check your policy for details). Copayments, coinsurance, non-covered services, or any charges in excess of any maximum or allowed amount are never applied to your deductible amount. Note: Your plan may have different deductible amounts for services in and out of the BCBS provider network.

Deductible types include:

Individual Deductible - If you have dependents on your policy, each person may have an individual deductible that is applied toward a total family deductible.

Family Deductible - Your family has a deductible for all covered members on your policy, if applicable. When the sum of all family member payments satisfies the family deductibles, each member begins to make payments at the coinsurance rate. Please note that some policies require that a specific number of family members must meet their individual deductibles first before the family deductible is met.

Coinsurance - Your share of the costs of a covered health care service, calculated as a percentage (for example, 20%) of the allowed amount for the service. You pay coinsurance plus any deductibles you owe. For example, if your plan's allowed amount for an office visit is $100 and you've met your deductible, your co-insurance payment of 20% would be $20. Your plan pays the rest of the allowed amount. Also, once you reach your coinsurance maximum, your plan will pay 100% for covered services for the rest of the benefit period.

Plan's Maximum - This is the specific deductible, coinsurance, or out-of-pocket amount for your plan, and what you may owe cannot exceed these amounts. This does not include copayments or non-covered services.

Out of Pocket - The total amount of coinsurance that you will pay during a policy period before your plan begins to pay at 100% of the allowed amount. This limit typically does not include your premium, copayments, deductibles, charges over allowed amounts, or services that are non-covered. Charges that are applied to your out-of-network coinsurance are credited to your in-network out-of-pocket maximum. However, charges applied to your in-network coinsurance are not credited to your out-of-network out-of-pocket maximum.