Insurance Guidance and Information Page

If you have health insurance, then please read the following information so that you completely understand how your insurance will work if it is utilized by a treatment provider.

PREFERRED PROVIDERS- Preferred providers are treatment facilities that hold a contract with your insurance carrier. Preferred providers are IN-Network with your insurance carrier and have already negotiated lower rates to provide you with treatment services. In most cases, if you enter into a facility which is considered a preferred provider with your health insurance carrier, your out of pocket co-payment costs will be considerably less than if you were to enter an non-preferred provider (or an OUT-OF-NETWORK) facility. To check if a program is a preferred provider with your health insurance company, you can simply call the customer service number on the back of your insurance card.

OUT OF NETWORK PROVIDERS- Many treatment facilities are considered OUT OF NETWORK with insurance carriers. If you have OUT OF NETWORK benefits on your health insurance policy, then more than likely, your insurance company will be willing to fund a portion of your treatment. If you admit to a facility that is considered OUT OF NETWORK with your insurance carrier, then it is likely that the out of pocket expenses incurred will be considerably higher than if you were to enter into an IN-Network facility. If you have OUT OF NETWORK benefits and enter into an OUT OF NETWORK facility, then your insurance carrier is expected to pay a premium rate for the treatment program.

INSURANCE DISCLAIMER- If you call your insurance company and ask about your benefits and eligibility to enter a facility, they will quote you a percentage of a daily rate and an amount of days that you will be eligible for treatment. The insurance company will ALWAYS make a disclaimer statement similar to the following: “This is a statement of benefits and eligibility and NOT a guarantee of payment, all services are subject to utilization review and are paid based on medical necessity”. What this means is, you may have the benefits for treatment services, but you will only qualify for the treatment services if your insurance company deems it medically and psychologically appropriate for you to be in treatment and receiving the services. In most cases, an insurance company will require weekly updates on your progress in a treatment facility. They will grant days of services based on your specific needs and progress.

QUESTIONS TO ASK YOUR INSURNACE CARRIER-

Which programs are IN-Network with my insurance?

Do I have OUT OF NETWORK benefits?

How many days of residential treatment am I eligible for?

How much will my out of pocket expenses be?

What is my deductible and how much has already been met?

Am I eligible for outpatient services? If so, how many days?