Glovan, Pollak and Associates LLC
THE BEHAVIORAL WELLNESS GROUP

CALLING YOUR INSURANCE COMPANY: INTENSIVE OUTPATIENT PROGRAM (IOP)

The following questions are helpful for you to ask of your insurance company, since mental health benefits at times are handled differently than your medical benefits. Please call the toll free number, usually on the back of your insurance card, for mental health/behavioral health benefits. If you don't have a card, check your benefits manual for the number. Please ask the following questions:

1. Are Intensive Outpatient Programs (IOP) covered under my plan? ____Y ____N

   - For the Dual Diagnosis IOP, HCPC Code H0015 with Revenue Code 0906
     Billed on UB04 (UB92) (sometimes called a "facility claim form")
   - For the Health/Wellness IOP, HCPC Code S9480 with Revenue Code 0905
     Billed on UB04 (UB92) (sometimes called a "facility claim form")
   - For the DBT IOP, HCPC Code S9480 with Revenue Code 0905
     Billed on UB04 (UB92) (sometimes called a "facility claim form")
   - For Evening Mental Health IOP, HCPC Code S9480 with Revenue Code 0905
     Billed on UB04 (UB92) (sometimes called a "facility claim form")
   - For the Adolescent IOP, HCPC Code S9480 with Revenue Code 0905
     Billed on UB04 (UB92) (sometimes called a "facility claim form")

2. The provider I am seeing is - Dr. John A. Glovan for Health and Wellness IOP
   - Mr. Michael J. Pollak for Dual Diagnosis IOP
   -Ms. Cathy Knezevich for DBT IOP
   -Ms. Stephanie Cerula for Evening Mental Health IOP
   -Ms. Erin Pawlak for Adolescent IOP

   Legal Name of Facility: Glovan, Pollak and Associates, LLC
   Doing Business As: The Behavioral Wellness Group
   Facility Tax ID: 46-5078878

3. If this facility is out of network for IOP, do I have out of network IOP benefits?
   ____Y ____N What is my out of network IOP benefit? _____

4. Do I need prior authorization? ____Y ____N Phone# _____

5. What is my annual mental health deductible? _____
   Is this per calendar year? ____Y ____N

6. Is there a limited number of IOP sessions per calendar year? ____Y ____N

7. What is my IOP copay/co-insurance? _____

8. Is there a maximum dollar amount per year that insurance will pay? _____

9. Is there an "out of pocket maximum" before insurance pays 100%? ____Y ____N

   $_____

Who Spoke With_____ Date_____

******Please complete and forward prior to or bring to your first appointment******