**INSURANCE BENEFIT INQUIRY**

**NEW ENGLAND PSYCHOLOGICAL ASSESSMENT CENTER, INC.**80 Flanders Road, Suite 102, Westborough, MA 01581 / 85 Constitution Lane, Suite 2C, Danvers, MA 01923  
Phone: (508) 366-2466 / Fax: (508) 366-2228 / Email: Info@nepacinc.com

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
*(if applicable)*

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
  
Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Referred by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Reason for Testing: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Blue Cross ID#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Subscriber: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Subscriber’s DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**REQUIRED:** Please call your insurance company (# on the back of the card) to request coverage information for each of the procedure codes listed below. Copays, coinsurance and/or deductible may (or may not) apply. A member service representative can provide you with this information which we ask that you provide in the section below. Please also ask the representative if prior authorization is needed for the testing. This form must be completed and submitted to us before we can schedule an appointment:

**Initial consult via telehealth (CPT# 90791)**

Copay:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Deductible: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Coinsurance: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Psychological/Neuropsychological testing (CPT# 96130, 96132 and 96116)**

Copay:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Deductible: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Coinsurance: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is authorization for testing required? \_\_\_\_\_Yes \_\_\_\_\_No

**Feedback Session (CPT# 90837)**

Copay:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Deductible: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Coinsurance: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Insurance representative name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Reference #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Call Date \_\_\_\_\_\_\_*Fax (508-366-22228) or email (**[**info@nepacinc.com**](mailto:info@nepacinc.com)**) completed form to us and you will be contacted for an appointment. Thank you.**