HEALING MINDS

Psychiatric-Mental Health Nurse Practitioner

Insurance Communication & Billing Authorization

This form authorizes Healing Minds to communicate with your insurance company regarding billing, eligibility, claims processing, and required clinical documentation for reimbursement purposes.

• PURPOSE OF DISCLOSURE:
To verify benefits, submit claims, process prior authorizations, or respond to insurance requests.

• INFORMATION THAT MAY BE DISCLOSED:
Diagnosis codes, treatment dates, service type, required documentation, and provider information.

• LIMITATIONS:
No psychotherapy session notes will be released. Only information required for billing or insurance operations will be disclosed.

• FINANCIAL RESPONSIBILITY:
I understand that I am financially responsible for all charges not covered or denied by insurance.

Full Legal Name: _____

Date of Birth (MM/DD/YYYY): _____

Insurance Company Name: _____

Member ID: _____

Signature (Typed Name): _____

Date: _____