Sample Deep TMS Benefit Quote

Date Verified: ___________________________

Insurance Company: ___________________________

Representative Name/Ref#: ___________________________

Effective Date: ___________________________

Plan Year: ___________________________

Copay (per day, per provider): ___________________________

Deductible: ___________________________

Coinsurance: ___________________________

Out-of-Pocket Maximum: ___________________________

Amount Met To-Date: ___________________________

Amount Remaining: ___________________________

% Covered After OPM: ___________________________

# of Sessions Allowed (based on insurance policy): ___________________________

Is Precertification Required? ___________________________

Total Out-of-Pocket Cost

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*Note: TMS therapy codes are showing in system as a covered benefit. This is based on medical necessity and under the insurance's coverage policy. Final payment and coverage is determined at time of submission. Contact your insurance company by calling the number on the back of your card; referencing TMS as an outpatient behavioral health procedure. CPT codes: 90867, 90868, 90869 for more information

Patient Signature: ___________________________

Date: ___________________________

*Your physician's office has obtained a benefit quote for above services as a courtesy to you. However, it is the patient's responsibility to know their benefits.