Coverage Checklist

General

Obtain a copy of your health plan's Summary of Benefits and Coverage document.

My health plan's out-of-pocket limit is: $_____

My coverage period is: _____

I have already paid $_____ toward my out-of-pocket limit during this coverage period.

Covered Providers

List all in-network providers needed for your treatment. Be sure to ask about your anesthesiologist, radiologist, and other doctors:

_____

_____

_____

List all out-of-network providers needed for your treatment. Be sure to ask about your anesthesiologist, radiologist, and other doctors:

_____

_____

_____

Covered Services

All of the services I need for my care are covered by my insurance: Yes/No (circle one).

The following services I need for my care not covered by my insurance:

_____

_____

_____

I am responsible for $_____ for these uncovered services.

Hospital services (applies to both inpatient and outpatient services)

I will be getting services in a hospital and will need:
___ Medical supplies
___ Durable medical equipment
___ An ambulance ride

These services are covered by my health plan: Yes/No (circle one).

For services not covered by my health plan, I am responsible for $_____ for those uncovered services.

Medications

List all of the medications you will need that listed in your health plan's preferred drug list:

_____

_____

_____

List all of the medications you will need that are NOT listed in your health plan's preferred drug list:

_____

_____

_____

I am responsible for $_____ for these non-covered medications.

Tests

Diagnostic agents will be used for some of the tests I need and these agents are covered by my health plan: Yes/No (circle one)

I am responsible for $_____ for any non-covered diagnostic agents needed for my treatment.

Mental health, behavioral health, or substance abuse needs

I will be receiving mental health, behavioral health, and/or substance abuse services *in an outpatient facility*, such as a rehabilitation facility. These services are covered by my health plan: Yes/No (circle one).

I am responsible for $_____for any mental health, behavioral health, and/or substance abuse services not covered by my health plan.
I will be receiving mental health, behavioral health, and/or substance abuse services *in a hospital*. These services are covered by my health plan: Yes/No (circle one).

I am responsible for $_____for any mental health, behavioral health, and/or substance abuse services not covered by my health plan.

Pregnancy

My health plan covers care for me when I give birth to my baby: Yes/No (circle one).

My health plan covers care for my baby when it is delivered: Yes/No (circle one).

My health plan covers care for me after I give birth to my baby: Yes/No (circle one).

My health plan covers care for my baby after it is delivered: Yes/No (circle one).

I am responsible for $_____ for the uncovered services needed for me and my baby.

Recovery and Special Needs

My health plan covers my recovery, including rehabilitation, vision, hearing, and speech: Yes/No (circle one).

I am responsible for $_____ for any uncovered recovery services.

Dental and/or Eye Care

My health plan covers the costs of my eye glasses, contact lenses, and/or other eyewear: Yes/No (circle one).

I am responsible for $_____ for uncovered eyewear.

My health plan covers the costs of any dental or orthodontic work: Yes/No (circle one).

I am responsible for $_____ for uncovered dental or orthodontic work.