



HANSEI
SOLUTIONS



Prepared by _____

Date _____

Start Time _____

Facility

Name _____ State _____ Tax ID _____ NPI _____

Subscriber

Name _____ SSN _____ DOB _____

Address _____ Gender ☐ F ☐ M

Email _____ Phone _____

Patient

Name _____ SSN _____ DOB _____

Relationship _____ Gender ☐ F ☐ M

Policy

Insurer _____ Plan Type _____ Phone # _____

Member ID _____ Group # _____ Effective _____

Expiry Term _____ Expires _____

Pre-Cert Company _____ Fax/URL _____ Phone # _____

Carve Out Insurer _____ BH ID _____ Phone # _____

BH Claims Address _____ Payor ID _____

Plan Sponsor _____ Funded ☐ Fully ☐ Self Employer _____

Primary ☐ Y ☐ N COB on file ☐ Y ☐ N Details _____

Flags and Limitations

TJC/CARF Required ☐ Y ☐ N ☐ DTX ☐ RTC ☐ PHP ☐ IOP RN Required ☐ Y ☐ N LVN Required ☐ Y ☐ N

In Grace Period ☐ Y ☐ N Last Payment _____ COBRA ☐ Y ☐ N

Periodic maximums ☐ Y ☐ N Time Period _____ Details _____

Limitations on # days ☐ Y ☐ N Details _____ Out of state benefits ☐ Y ☐ N

Notification Requirement _____ Pre-Cert Penalty _____

Payments go to ☐ Member ☐ Facility Are AOBs accepted ☐ Y ☐ N

Patient Responsibility

Does deductible apply to OOP ☐ Yes/Combined ☐ No/Separate

Do IN and OON cross accumulate ☐ Y ☐ N

Individual				Family <input type="checkbox"/> N/A			
		OON <input type="checkbox"/> N/A				OON <input type="checkbox"/> N/A	
Max		Max	Met	Max		Max	Met
Deductible							
OOP							
Notes							

☐ No Max OOP ☐ 4th quarter carryover applies

Reimbursement

Substance Abuse			Mental Health		Co-Pay	Notes
IN	OON	IN	OON			

Rate Table _____ Details _____ 3rd Party Repricing _____

Summary

Information Provided by

Rep Name _____ Company _____ Ref # _____
 Rep Name _____ Company _____ Ref # _____
 End Time _____