GARRISON CITY THERAPY SERVICES

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Guide to Out-of-Network Benefits 2026

HOW TO SEEK INSURANCE REIMBURSEMENT FOR OUT-OF-NETWORK SPEECH THERAPY

Because insurance reimbursement rates no longer cover the basic overhead required to provide high-quality, individualized care, our practice operates on a private-pay model for many insurance companies. This means payment is collected at the time of service directly from the patient/caregiver for services rendered. However, your insurance plan may have "Out-of-Network (OON)" benefits that will refund you for a portion of our services. Here is your step-by-step guide to navigating this process.

STEP 1: CALL YOUR INSURANCE PROVIDER

Before your first session, call the member services number on the back of your insurance card. Ask the representative the following exact questions:

1. "Does my plan provide out-of-network benefits for speech therapy (outpatient habilitative/rehabilitative services)?"
2. "Do I have an out-of-network deductible that must be met before reimbursement kicks in? If so, how much is it and how much has been met this year?"
3. "What percentage of the 'allowed amount' does my plan cover for an out-of-network speech therapist?"
4. "Does my plan require a physician's referral for out-of-network speech therapy?
5. "Does my plan require prior-authorization for out-of-network speech therapy? If so, how do I obtain this authorization?"
6. "How many speech therapy sessions does my plan allow per 12-month period? Does my plan run on a calendar year or plan year basis? If a plan year, what are the dates? Are the allowed sessions combined with other services such as OT, PT, chiropractic care, etc.?"
7. "Does my plan have any exclusions for speech therapy?"
8. "How do I submit an out-of-network claim? Is there an online member portal, or must I mail a CMS-1500 form?"

STEP 2: RECEIVE AND SUBMIT YOUR SUPERBILL

- At the end of each month (or earlier if requested), we will provide you with a "Superbill" by secure email.
- This is an itemized invoice that contains all the patient information, exact codes, provider credentials, and clinical descriptions required by insurance companies.
- You will submit this Superbill directly to your insurance company via their online portal or mail.

STEP 3: TRACK YOUR CLAIMS

- Insurance companies typically process OON claims within 30 to 45 days.
- Keep a log of every Superbill you submit, the date you submitted it, and any correspondence you receive.
- If a claim is denied, look at the "Explanation of Benefits" (EOB) sheet to see why. Often, it is a simple missing detail (like a typo in the DOB) that can be easily fixed and resubmitted.

Please let us know if your insurance provider requires specific clinical documentation alongside your Superbill; we are happy to provide the necessary documentation via secure email to support your/your family's reimbursement.

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