

How to submit a superbill

A step-by-step guide to asking your insurance plan for out-of-network reimbursement.

Start here: A superbill is an itemized document from your therapist. It is not an insurance claim by itself. You usually submit it with your plan's member claim form after paying for care. Coverage and reimbursement depend on your specific plan and are not guaranteed.

1. Check your benefits and filing deadline.

Call the Member Services number on your insurance card or use your plan's secure portal. Ask whether your specific plan covers out-of-network outpatient mental health care **by telehealth**. Confirm any referral or authorization requirements, your remaining out-of-network deductible, coinsurance, and how the plan sets its allowed amount. Ask how many days you have to submit a claim, measured from each date of service.

Ask: "Which member claim form should I use for out-of-network telehealth therapy? Where do I send it, what documents do you need, and what is the filing deadline?" Write down the representative's name and call reference number.

2. Request your superbill and proof of payment.

Ask Megan for a superbill covering the sessions you want to submit. Keep any receipt the insurer requires. Review your name, dates of service, charges, provider details, diagnosis and procedure codes. If anything seems missing or incorrect, ask Megan to review it. **Do not add, change, or guess clinical or billing codes yourself.**

3. Complete your plan's member claim form.

Use the form supplied by your insurer. Enter your member ID and patient and policyholder details exactly as they appear in the plan's records. Answer all required questions, sign and date it, and attach the superbill and any required receipts. Ask the insurer which provider fields should be copied from the superbill.

Privacy note: Superbills generally include a mental health diagnosis. Submitting one shares that information with your insurer. If you have concerns, talk with Megan before submitting.

Submit, track, and follow up

Keep a copy of everything you send. Use the tracker on the next page to keep the details in one place.

4. Submit through the insurer's approved channel.

Upload your claim form and supporting documents to the secure member portal, or use the mailing address or other method your insurer specifies. Check that uploads are readable and complete. Avoid sending sensitive health information through ordinary email unless your insurer specifically directs you to an approved secure method. Save the confirmation number, screenshot, or mailing proof and submission date.

5. Watch for the Explanation of Benefits (EOB).

Ask how long claims usually take and when to follow up. Track the claim in your member portal. If it is not listed or remains pending beyond that timeframe, contact Member Services with your claim number, submission date, and dates of service. An EOB explains how the claim was processed; it is not a bill and does not always mean a payment will be issued.

Compare the EOB with your records: submitted charge, allowed amount, deductible applied, coinsurance, payment amount, and who receives payment. If the claim is covered but your deductible has not been met, it may count toward that deductible without paying you back yet.

6. Resolve missing information or a denial.

Ask for the specific reason and what is needed to correct it. For missing or incorrect provider information, ask Megan for a corrected superbill if appropriate. For benefit or processing questions, work with your insurer. If you disagree with a denial, request the appeal instructions and deadline shown on the EOB. Keep copies of your correction or appeal and confirmation. Ask how to avoid filing a duplicate claim.

A simple example, not a payment promise: If a session costs \$185, the plan's allowed amount is \$120, your out-of-network deductible is already met, and the plan pays 60% of the allowed amount, the payment could be \$72. Your cost would be \$113. If your deductible is not met or the service is not covered, the payment could be \$0. Your plan may calculate benefits differently.

Questions about your superbill?

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For coverage decisions, claim status, or appeal deadlines, contact your insurer. This guide is general education, not a guarantee of benefits or a substitute for your plan's instructions.

Your submission checklist

Use this page for your own records. Store completed copies securely because they may contain health and insurance information.

- ☐ Confirmed out-of-network telehealth benefits and filing deadline
- ☐ Requested and checked superbill; gathered required receipts
- ☐ Completed and signed insurer's member claim form
- ☐ Submitted through approved channel; saved all copies and confirmation
- ☐ Reviewed EOB and payment or deductible application
- ☐ Followed up, corrected information, or appealed if needed

Claim tracker

Insurer / plan

Dates of service / total paid

Filing deadline / submission date

Submission method / confirmation number

Claim number / expected processing time

Representative / call date / reference

EOB date / allowed amount

Deductible applied / payment / payee

Next action / follow-up or appeal deadline

Keep the superbill, receipts, completed form, submission confirmation, EOB, and follow-up notes together.