Mental Health Parity Story Collection Form

Have you or someone you know been denied coverage for mental health or substance use disorder treatment in the state of Arizona? If so, the Arizona Coalition for Insurance Parity wants to hear from you.

The Arizona Coalition for Insurance Parity is collaboration between the Arizona Council of Human Service Providers, JEM Foundation, Mental Health America of Arizona, and the Neighbors Council. We are working to ensure that Arizonans are able to easily access appropriate and timely mental health and substance use disorder treatment through their medical insurance.

Please fill out this survey if you, or someone you know, has been unable to access needed behavioral health services or had a claim denied for mental health and/or substance use disorder treatment. The information you provide will help us to shape public policy and influence legislation in order to move us towards full parity implementation and mental health equity.

By completing this survey you are acknowledging that your information is being collected to help understand the current trends and circumstances surrounding mental health and substance use disorder treatment claim denials in Arizona. All information you provide will be kept confidential, and any identifiable information you choose to provide will not be shared without your permission.

The story you are sharing may be about yourself or may be about someone you know well. If you are sharing a story on behalf of someone else, are you:

☐ A parent
☐ Other relative
☐ A friend
☐ A therapist or other mental health provider
☐ A teacher or other school employee
☐ I am sharing my own experience
☐ Other_____

If you are sharing a story on behalf of someone else, please respond to the questions below from the perspective of the individual impacted.

1. Are you (Check all that apply):
   ☐ A student
   ☐ Currently employed
   ☐ Unemployed
   ☐ Retired
   ☐ State or local government employee
   ☐ Other _____
   ☐ Federal employee
   ☐ Member of a union
   ☐ Currently in the military
   ☐ A veteran

Age:

☐ 0-9
☐ 10-17
☐ 18-25
☐ 26-35
☐ 36-45
☐ 46-55
☐ 56-64
☐ 65 and over

Gender:

☐ Male
☐ Female
☐ Prefer to self-describe _____
☐ Non-binary/third gender
☐ Prefer not to answer

What county do you live in?

☐ Apache
☐ Cochise
☐ Coconino
☐ Gila
☐ Graham
☐ Greenlee
☐ La Paz
☐ Maricopa
☐ Mohave
☐ Navajo
☐ Pima
☐ Pinal
☐ Santa Cruz
☐ Yavapai
☐ Yuma

What is your home zip code? _____

2. What issues were you having that caused you to seek mental health or substance use disorder treatment? (Check all that apply):

☐ Autism Spectrum Disorder
☐ Bipolar Disorder
☐ Concerns with alcohol and/or drug use
☐ Difficulty focusing on tasks
☐ Difficulty managing anger
☐ Difficulty managing anxiety
☐ Domestic Violence
☐ Eating Disorder
☐ Feelings of depression
☐ Hearing or seeing things that others do not hear or see
☐ Loss of contact with reality
☐ Not able to take care of myself
☐ Obsessive-compulsive thoughts or behaviors
☐ Other _____
☐ Panic attacks
☐ Personality Disorders
☐ Post-Traumatic Stress Disorder
☐ Problems at school
☐ Problems with my marriage
☐ Relationship Issues
☐ Schizophrenia
☐ Severe shifts in mood, energy, and/or activity level
☐ Sexual assault or molestation
☐ Suicidal thoughts or attempts
☐ Trauma history

3. What help were you hoping to receive? (Check all that apply)

<u>Outpatient Services:</u>

☐ Autism Services (behavior coaches, ABA therapy)
☐ Group Mental Health Therapy or Counseling
☐ Individual Mental Health Therapy or Counseling
☐ Intensive Outpatient Services (day treatment, evening care)

☐ Ongoing Support or Pro-Active Support (psychiatrist and/or therapist)
☐ Peer and/or Family Support Services
☐ Prescription Drugs
☐ Testing by Mental Health Professional
☐ Other Outpatient Services

Inpatient Services:
☐ Inpatient Hospitalization – Emergency Room
☐ Inpatient Hospitalization – Mental Health Hospital
☐ Inpatient Residential Treatment Facility
☐ Partial Hospitalization

Substance Use Disorder Services:
☐ Medication Assisted Treatment (MAT)
☐ Outpatient Substance Use Disorder Treatment
☐ Treatment by an Addiction Specialist
☐ Withdrawal Management (e.g. detox)

☐ I'm not sure
☐ Other (Please Specify) _____

4. What is the name of your insurance company?

☐ Aetna	☐ Cigna	☐ Oscar Health Plan
☐ All Savers	☐ Health Net	☐ TRICARE
☐ Ambetter	☐ Humana	☐ United Healthcare
☐ Banner	☐ Medicaid	☐ WMI Mutual
☐ Blue Cross/Blue Shield	☐ Medicare	☐ I'm not sure
☐ Bright Health	☐ National Health	

☐ Other (Please Specify) _____

What type of insurance plan do you have? (HMO, PPO, High Deductible Plan, or other?)
☐ HMO
☐ PPO
☐ High Deductible Plan
☐ I'm not sure
☐ Other (Please Specify) _____

5. Have you received any of the care you were seeking or requesting?
☐ Yes, I received everything I sought/needed
☐ No, I did not receive any of the care I sought/needed
☐ Some, but not all of the care I sought/needed

If you answered "no" or "some", what services didn't you receive? (Check all that apply)

Outpatient Services:
☐ Autism Services (behavior coaches, ABA therapy)
☐ Group Mental Health Therapy or Counseling
☐ Individual Mental Health Therapy or Counseling
☐ Intensive Outpatient Services (day treatment, evening care)
☐ Ongoing Support or Pro-Active Support (psychiatrist and/or therapist)
☐ Peer and/or Family Support Services
☐ Prescription Drugs
☐ Testing by Mental Health Professional
☐ Other Outpatient Services

Inpatient Services:
☐ Inpatient Hospitalization – Emergency Room
☐ Inpatient Hospitalization – Mental Health Hospital
☐ Inpatient Residential Treatment Facility
☐ Partial Hospitalization

Substance Use Disorder Services:
☐ Medication Assisted Treatment (MAT)
☐ Outpatient Substance Use Disorder Treatment
☐ Treatment by an Addiction Specialist
☐ Withdrawal Management (e.g. detox)

☐ I'm not sure
☐ Other (Please Specify) _____

If you answered "no" or "some", why haven't you received the full care you were seeking? (Check all that apply)
☐ I could not get an appointment.
☐ The wait time was too long.
☐ I could not find a provider close enough that I could get there easily.
☐ I gave up because I got frustrated trying to arrange for or find care.
☐ I could not find a culturally appropriate provider.
☐ I could not find a provider able to communicate with me in my preferred language.
☐ There is no provider who will take my insurance or was in my insurer's network.
☐ My insurance does not cover providers that are out of the network.
☐ My insurance does not cover mental health or substance use disorder treatment.
☐ My insurance limited the number of days of inpatient care I was eligible to receive.
☐ My insurance refused to pay and I could not cover the out of pocket costs.
☐ My insurance refused to pay for additional days of inpatient care recommended by my doctor.
☐ My insurance told me that I needed to try a different type of treatment first.
☐ Other (Please Specify) _____

6. If your insurer denied your claim or request for services or did not pay for it, what was the explanation? (Check all that apply)
   ☐ My plan excludes this coverage/it is not a covered benefit.
   ☐ My plan limits the number of visits for this service.
   ☐ My plan claims that the care was not medically necessary.
   ☐ I did not get prior-authorization or prior approval for this service.
   ☐ My provider/facility was not in network
   ☐ The treatment was considered experimental
   ☐ I don't know
   ☐ Other (Please Specify) _____

7. If you were denied care, have you filed an appeal or complaint with your insurance company?
   ☐ Yes, I have filed an appeal or complaint
   ☐ No, I have not filed an appeal or complaint
   ☐ Yes, the provider filed an appeal or complaint for me
   ☐ I'm not sure

8. If you were denied care, have you filed a complaint with the Arizona Department of Insurance?
   ☐ Yes, I have filed a complaint
   ☐ No, I have not filed a complaint
   ☐ Yes, the provider filed a complaint for me
   ☐ I'm not sure

9. Would you be interested in publically sharing your story to help improve mental health and substance use insurance coverage? This means that someone from the Arizona Coalition for Insurance Parity might be contacting you.

   ☐ Yes
   ☐ No

   If yes, please provide your name, phone number, and/or email address so we can contact you: _____

10. In your own words, tell us about your experience. Please do not include identifiable information, such as names, addresses, social security numbers, etc. Use additional pages as necessary.

_____
_____
_____
_____
_____

To file a complaint with the Department of Insurance, please visit their website: https://insurance.az.gov/consumers.

If you would like more information on insurance parity and your rights, please visit www.DontDenyMe.org.

Please return this form to Amy Meyertholen, Arizona Council of Human Service Providers, amy@azcouncil.com or fax 602.252.8664. If you have questions about this survey or mental health parity, please contact Amy Meyertholen.

Thank you for helping us gather information about access to mental health and substance use disorder treatment.