

INSURANCE VERIFICATION FORM

PATIENT NAME: _____ **DATE:** _____

Health Insurance has become very complicated over the past few years. Our office staff will help you as much as we can but, *it is ultimately your responsibility to understand your particular plan. Often insurance companies limit visits for Physical Therapy Treatment.* It is important to both of us to know as soon as possible about any limits on your insurance coverage. This information helps your physical therapy treatment flow smoothly without interruption.

Please contact your insurance company directly and ask the following questions with regards to Physical Therapy treatment:

PRIMARY INSURANCE: _____

ID NUMBER: _____

ADDRESS TO SEND CLAIMS: _____

1. Does my insurance cover Physical Therapy treatment? Yes _____ No _____
2. How many visits does my plan allow? # of visits: _____
3. If more visits are needed, what do I need to do? _____

4. Does my plan stop coverage after a period of time or after a certain number of visits? # weeks: _____
visits: _____
5. How much is the deductible on my plan and how much have I met this year? Deductible Amt \$: _____
Amount met: \$ _____
6. What is my out of pocket per year? Out of Pocket: \$ _____
7. Do I have any co-payments? Yes _____ No _____
If so, is the co-pay per visit? Per Visit Amount: \$ _____
Or one time only? One Time Amount: \$ _____
8. Is there a primary care physician referral on record? Yes _____ No _____
9. What is the referral ^{phone} number? _____

PLEASE RETURN THIS FORM AT YOUR NEXT VISIT