THERAPY VERIFICATION OF BENEFITS

Patient Name: _____ Medical Record #: _____

Insurance Company: _____ Ordering Provider: _____

Member ID: _____ Diagnosis code: _____

DOB: _____

As a courtesy and to better serve our patients, physical therapy and /or occupational therapy benefit information has been obtained and listed below. **Please be advised this information is obtained by phone, internet, mail or fax and is not a guarantee of payment for services**. **The information below is strictly an estimate based on information obtained from your insurance carrier. You may have some out-of-pocket financial responsibility as determined by your insurance carrier once claims are processed.** It is ultimately the responsibility of the individual policy holder to understand and confirm their benefits.

Representative: _____ Effective Date: _____

Co-payment each visit: $_____ Reference Number: _____

Please note, if you have **not met** the full deductible for your plan, we will collect $65 per visit as you attend therapy. **Once the claims are processed by your insurance company you will be billed for any remaining balance for which you are responsible according to your insurance benefits.**

Individual Deductible: $ _____ Family Deductible: $_____

Deductible Met? Yes ☐ No ☐ If no, deductible balance remaining: $_____

Signing on the line below acknowledges that you are aware your deductible has not been met, and you will be responsible for payment as noted above. _____ **Patient's Initials**

Once deductible is met (or if you have no deductible at all), you may still have co-insurance and may have additional financial responsibility as stated below:

A _____ % covered by insurance of customary and usual charges.

B _____ % patient responsibility of customary and usual charges. Note: _____

(The sum of Line A and Line B above must equal 100% unless otherwise noted) _____ Patient's Initials

Out of pocket max: $ Authorization or referral required:

Amount met to date: $ If yes, Authorization #:

Maximum(s) allowed for therapy:
Other limitations:

Type of Service: Locations: Evaluation Date:

Benefits obtained by: Date:

The undersign certifies that they accept the terms/financial responsibility as stated above.

_____ _____

Signature **Date**