

Patient Name:

Account Number:

Insurance Information			
Only complete the following if the Primary or Secondary policy holder is not the patient.			Primary <input type="checkbox"/> Secondary <input type="checkbox"/>
Last Name:	First Name:	Middle Initial	SSN
		DOB	
Patient Relationship to Policy Holder: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other		Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	
Employer Name:		Employer Phone #:	
Primary Insurance Section		Secondary Insurance Section	
Payor/Plan		Payor/Plan	
Code:		Code:	
Policy/ID #:	Group #:	Policy/ID #:	Group #:
Insurance Phone #:		Insurance Phone #:	
<u>All Information Below "FOR OFFICE USE ONLY"</u>		<u>All Information Below "FOR OFFICE USE ONLY"</u>	
Verification		Verification	
AT: _____ FSC: _____			
Date:	Spoke with:	Date:	Spoke with:
Verify Plan: _____ Effective Date: _____		Verify Plan: _____ Effective Date: _____	
Is this a Federally Funded Plan? <input type="checkbox"/> Yes <input type="checkbox"/> No		Is this a Federally Funded Plan? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Does patient have both PT and/or OT coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No		Does patient have both PT and/or OT coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Informed Payor this is outpatient therapy performed in an office setting. <input type="checkbox"/>		Informed Payor this is outpatient therapy performed in an office setting <input type="checkbox"/>	
Visit Limitation:	Coverage:	Visit Limitation:	Coverage:
Limitations on Modalities or Units? Home Program/97535 ___ Anodyne/97026 ___ Aquatic/97113 ___ Other ___ / ___ / ___		Limitations on Modalities or Units? Home Program/97535 ___ Anodyne/97026 ___ Aquatic/97113 ___ Other ___ / ___ / ___	
Comments/Special Instructions:		Comments/Special Instructions:	
Deductible: \$ Met: <input type="checkbox"/> Yes <input type="checkbox"/> No	Out Of Pocket: \$ Met: <input type="checkbox"/> Yes <input type="checkbox"/> No	Deductible: \$ Met: <input type="checkbox"/> Yes <input type="checkbox"/> No	Out Of Pocket: \$ Met: <input type="checkbox"/> Yes <input type="checkbox"/> No
Does patient have a co-pay? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, amount: \$ Per Visit? <input type="checkbox"/> IE/Re-eval only? <input type="checkbox"/>		Does patient have a co-pay? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, amount: \$ Per Visit? <input type="checkbox"/> IE/Re-eval only? <input type="checkbox"/>	
Required for therapy? <input type="checkbox"/> Referral <input type="checkbox"/> Authorization <input type="checkbox"/> Pre-Cert If any of the above is required, verify that it is on file? <input type="checkbox"/>		Required for therapy? <input type="checkbox"/> Referral <input type="checkbox"/> Authorization <input type="checkbox"/> Pre-Cert If any of the above is required, verify that it is on file? <input type="checkbox"/>	
Auth #: _____ # of Auth Visits: _____ Auth Start Date: _____ Auth Exp Date: _____		Auth #: _____ # of Auth Visits: _____ Auth Start Date: _____ Auth Exp Date: _____	
Claims Address:		Claims Address:	

Verification (Workers Compensation)

Is this a State Funded <input type="checkbox"/> or Self Insured plan <input type="checkbox"/> (call employer)	Plan Name: _____
Claim Number: _____	Dx Codes on file: _____
<input type="checkbox"/> Allowed <input type="checkbox"/> In Process <input type="checkbox"/> Pending <input type="checkbox"/> Hearing <input type="checkbox"/> Other	
Adjuster Name: _____	Phone: _____ Fax: _____
Nurse/Case Manager Name: _____	Phone: _____ Fax: _____
Additional Notes:	

Verified By: _____ Date: _____