

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 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: _____

Does my insurance cover Physical Therapy treatment? Yes ___ No ___

How many visits does my plan allow? # of visits _____

If more visits are needed, what do I need to do? _____

Does my plan stop coverage after a period of time? # Weeks: _____

Or after a certain number of visits? # Visits: _____

How much is the deductible on my plan Deductible amount \$: _____

And how much have I met this year? Amount met \$: _____

What is my out of pocket per year? Out of Pocket\$: _____

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 \$: _____

Do I need a referral from my Primary Care Doctor? Yes ___ No ___

If you require a referral from your Primary Care Doctor, please contact them directly for this. You may have your physician fax one in to our office at 603-431-9701.

PLEASE BE SURE THAT YOU HAVE FILLED OUT THIS FORM COMPLETELY AND RETURN THIS FORM AT YOUR NEXT VISIT.