

I.E.	Follow-Ups:

Insurance Verification Form (For Office Use Only) Date:

Patient Name:	<u>General</u>	Dx:	
Patient email:	Patient Name:	DOB:	
Primary Insurance: D#:	Patient Phone #:Addres	s:	
Insurance Phone #: Type (PPO, HMO, ETC): Secondary Insurance: ID #: Group #: Insurance Phone #: Additional Info: Verification In-Network / Out-of-Network Eligible: Date Verified: Rep: Co-Pay: \$ / Co-Insurance: / % Other: Deductible: Y/N Deductible Amount: \$ / Fam Deduct: \$ / Deductible Wet: \$ / Fam Deduct Met: \$ / Out of Pocket Max: \$ / Out of Pocket Max: \$ / Out of Pocket Met: \$ / Visit Limitation: Yes / No # Med. Review: Yes/No. After # Visits Calendar Year / Policy Year Dates: () Out of State benefits?: Yes/No PT/OT/ST: Yes / No Therapy Cap: Yes / No Therapy Cap (Allowed/Used to Date): / Authorization Referral Req. From PCP: Yes / No Prior-Auth Req: Yes/ No Checked codes: Yes/No [myoptum]:Yes / No Prior-Authorization Information: Code Limitations/Acceptations (G0283?): ***CONFIRMATION # OF VERIFICATION CALL: Additional Info: I understand that this is an estimate may differ from my actual benefits and I may receive a bill for any remaining balance after my claims have been processed by my insurance company. I am responsible for any balance not covered by my insurance. I will notify Therapydia of any changes to my insurance.	Patient email:	Referred by:	
Insurance Phone #:	Primary Insurance:		
Secondary Insurance: ID #:	ID #:	_ Group #:	
Insurance Phone #:	Insurance Phone #:	_ Type (PPO, HMO, ETC):	
Network Out-of-Network Eligible:	Secondary Insurance:		
Verification In-Network / Out-of-Network Eligible:	ID #:	_ Group #:	
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Co-Pay: \$/ Co-Insurance:/ % Other:	<u>Verification</u>		
Deductible: Y/N Deductible Amount: \$/ Fam Deduct: \$/ Deductible Met: \$/ Fam Deduct Met: \$/ Out of Pocket Max: \$/ Fam Out of Pocket Max: \$/ Out of Pocket Met: \$/ Fam Out of Pocket Met: \$/ Visit Limitation: Yes / No #/ Med. Review: Yes/No. After # Visits	In-Network / Out-of-Network Eligible:	Date Verified:Rep:	
Deductible Met: \$	Co-Pay: \$ Co-Insurance	:% Other:	
Out of Pocket Max: \$	Deductible: Y/N Deductible Amount: \$/	/ Fam Deduct:\$/	
Out of Pocket Met: \$	Deductible Met: \$/	_Fam Deduct Met :\$/	
Visit Limitation: Yes / No # / Med. Review: Yes/No. After # Visits	Out of Pocket Max: \$/	_ Fam Out of Pocket Max: \$/	
Calendar Year / Policy Year Dates:(Out of Pocket Met: \$/	_Fam Out of Pocket Met: \$/	
PT/OT/ST: Yes / No Therapy Cap: Yes / No Therapy Cap (Allowed/Used to Date):/	Visit Limitation: Yes / No #/	Med. Review: Yes/No. After # Visits	
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	Patient Signature:	Date:	

 \square New Patient Call Sheet \square Initial Intake Email \square HIPPA/Questionnaire \square Scanned into WebPT \square Verified benefits w/PT