therapydia
Physical therapy discovered

I.E. _____ Follow-Ups: _____

Insurance Verification Form (For Office Use Only) Date:_____

General Dx: _____

Patient Name: _____ DOB: _____

Patient Phone #: _____ Address: _____

Patient email: _____ Referred by: _____

Primary Insurance: _____

ID #: _____ Group #: _____

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 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_____

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 of my expected payment regarding deductible/benefits. Therapydia will collect a portion of my payment due at time of service. This 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 Signature: _____ Date: _____

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