The Physical Therapy & Wellness Institute
"Bodies Under Repair"™

Patient Self Insurance Verification Questionnaire

BEFORE YOU CALL YOUR INSURANCE COMPANY, HAVE READY:

You name (as on your card): _____ Birth Date:_____

Subscriber Name (spouse/parent):_____ Birth Date:_____

ID Number: _____ Group Number: _____

Diagnosis(if possible/would be on prescription from doctor): _____

WHEN YOU CALL YOUR INSURANCE COMPANY SAY:

"I am calling to verify my insurance for Physical Therapy in an **OFFICE** setting"

Note the date/time and person you are speaking with: _____

If they ask where you are having your therapy: Physical Therapy & Wellness Institute

THEY WILL TELL YOU:

Effective date of insurance: _____

Current deductible: _____ How much deductible has been met for the year: _____

Co-Pay: _____ **Co-Insurance**: % Insurance will pay: _____ % Your responsible for: _____

Number of visits allowed: _____ per time limit: _____ (days/year) # visits used: _____

Yearly/Lifetime maximum: _____

Combined with Speech Therapy? Occupational Therapy? Chiropractic?

Out of pocket maximum_____ Then claims paid at _____%

Is pre-certification or prior authorization for treatment required? Yes/No

Phone Number to call for authorization:_____

Is authorization required at any time? _____

Is a referral required from the family physician? Yes/No