Personalized Therapy, LLC

Occupational & Physical Therapy for Children & Adults

BENEFIT VERIFICATION

BASIC INFORMATION

Patient Name _____ DOB: _____
Last First MI

Insured Name _____ DOB: _____
Last First MI

INSURANCE INFORMATION

Insurance Company Name:: _____ Phone Number _____ Fax Number _____

Adjuster or Claims Representative: _____ Phone Number _____ Fax Number _____

Policy Number _____ Group # _____ Employer Group Name: _____ Claim Number: _____

Patient Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

REFERRAL INFORMATION

ICD-9: Diagnosis Rehab Diagnosis Frequency/Duration

Referring Doctor _____ Office Number _____ Office Fax _____

Primary Care Physician _____ Office Number _____ Office Fax _____

Referring Physician NPI _____ Primary Care Physician NPI _____

INSURANCE AUTHORIZATION INFORMATION

Method Used: ☐ Internet ☐ Phone via ☐ Automated ☐ Customer Service Rep _____ Reference # _____

Date Requested: _____ Requested By: _____ Date Completed: _____ Completed By: _____
Time Requested: _____ Time Completed: _____

Insurance Company Contact: _____ Phone Number _____ First Visit: _____

Policy Effective Date: _____ Date of Injury: _____ Is Outpatient Therapy Covered? ☐ Yes ☐ No

DEDUCTIBLE Deductible Start Amount $: _____ Remaining Amount $: _____ Renewal Date: _____

COPAY	Patient Coinsurance %:	Patient Copay:	Out of Pocket Limit:	Clinic in Network:	Therapist in Network:
LIMIT #!	☐ Per Condition ☐ Per Calendar Year ☐ Per Benefit Year	Visits:	Consecutive Days:	$ Amount:	Treatment Time:

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PHONE: 301.862.2505 • FAX: 301.862.2548

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BENEFIT VERIFICATION

Limit #2	☐ Per Condition ☐ Per Calendar Year ☐ Per Benefit Year	Visits:	Consecutive Days:	$ Amount:	Treatment Time:

How much of limit #1 has been used?:	How much of limit #2 has been used?:	Precertification Need? ☐ Yes ☐ No

Therapy Authorization #:	# of Visits:	Authorization From:	Authorization To:

Insurance Billing Name:	Insurance Billing Address:

Attachment Requirements: ☐ Evaluation ☐ Plan of Care ☐ Copy of RX ☐ Daily Notes ☐ Progress Note ☐ Other

Reauthorization Contact Name: Phone #: Fax #:

Notes:

PATIENT AUTHORIZATION, RELEASE AND SIGNATURE

I have read the above estimation of benefits from my insurance company and agree to verify this information by reading my insurance benefits book or contacting my insurance company. I do not hold Personalized Therapy, LLC or its affiliates responsible for any incorrect or omitted information or for any changes in my future coverage. I also agree that I am responsible for the contract between my insurance company and myself.

Patient/Guardian Signature: **Date:**

MISCELLANEOUSE COMMENTS FROM BUSINESS OFFICE

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