PRIMARY INSURANCE BENEFIT VERIFICATION

PHYSICAL THERAPY CARE & AQUATIC REHAB OF FORT BEND

TO BE COMPLETED BY PATIENT

Patient last name	Suffix	First name	MI	D.O.B
Insured last name (if different)	**Suffix**	**First name**	**MI**	**D.O.B**

Patient relationship to insured: ☐ Self ☐ Spouse ☐ Dependent ☐ Other

PRIMARY INSURANCE INFORMATION

Insurance Coverage Name	Address	
Insurance Company Name	Phone Number	Fax Number
Adjustor or Claim Representative	Phone Number	Fax Number
Policy Number / Social Security Number	Group Number	Employer Group Name

Type of insurance company: ☐ HMO ☐ POS ☐ LOP ☐ Medicaid ☐ PPO ☐ Workmen's Comp ☐ Medicare ☐ PIP

CLINIC USE ONLY

Is Physical Therapy Care a network provider? ☐ **Yes** ☐ **No**

Completed by:	Date Requested:	Policy Effective Date:	Filing Deadline:
Rep Name:	Calendar/Group Plan year	If group, year start date	

PRIMARY BENEFITS

	Yes	No	Co-pay amount	
Does pre-existing apply?			Co-pay %	
Deductible met?			Deductible amount	
OOP met?			OOP	
Pre-certification required?			Pre-certification #	
Is there maximum benefit coverage for patient?			If yes, how much	
For HMO or POS only				
PCP referral required?			PCP name:	PCP phone:
For Medicare as primary insurance only			Are they receiving the following services?	
Do claims cross over?			☐ Home Health	
Is this a carve-out plan?			☐ Skilled Nursing	
Is this a managed plan?			☐ Hospice	

Comments

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 Physical Therapy Care & Aquatic Rehab of Fort Bend and/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 myself and my insurance company.

Patient/Guardian Signature: _____ **Date:** _____

Form: BOM 128e Revised: 08/27/2014

SECONDARY INSURANCE BENEFIT VERIFICATION

TO BE COMPLETED BY PATIENT

Patient last name	Suffix	First name	MI	D.O.B
Insured last name (if different)	Suffix	First name	MI	D.O.B

Patient relationship to insured: ☐ Self ☐ Spouse ☐ Dependent ☐ Other

SECONDARY INSURANCE INFORMATION

Insurance Coverage Name	Address	
Insurance Company Name	Phone Number	Fax Number
Adjustor or Claim Representative	Phone Number	Fax Number
Policy Number	Group Number	Employer Group Name

Type of insurance company: ☐ HMO ☐ POS ☐ LOP ☐ Medicaid ☐ PPO ☐ Workmen's Comp ☐ Medicare ☐ PIP

CLINIC USE ONLY

Is Physical Therapy Care a network provider? ☐ **Yes** ☐ **No**

Completed by:	Date Requested:	Policy Effective Date:	Filing Deadline:
Rep Name:	Calendar/Group Plan year	If group, year start date	

SECONDARY BENEFITS

	Yes	No	Co-pay amount	
Does pre-existing apply?			Co-pay %	
Deductible met?			Deductible amount	
OOP met?			OOP	
Pre-certification required?			Pre-certification #	
Is there maximum benefit coverage for patient?			How much	
For HMO or POS only				
PCP referral required?			PCP name:	PCP phone:
Comments				

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 Physical Therapy Care & Aquatic Rehab of Fort Bend and/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 myself and my insurance company.

Patient/Guardian Signature: _____ **Date:** _____