

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: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent <input type="checkbox"/> 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 <input type="checkbox"/> HMO <input type="checkbox"/> POS <input type="checkbox"/> LOP <input type="checkbox"/> Medicaid <input type="checkbox"/> PPO <input type="checkbox"/> Workmen's Comp <input type="checkbox"/> Medicare <input type="checkbox"/> PIP				

CLINIC USE ONLY	Is Physical Therapy Care a network provider?		<input type="checkbox"/> Yes	<input type="checkbox"/> 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				
Do claims cross over?			Are they receiving the following services? <input type="checkbox"/> Home Health <input type="checkbox"/> Skilled Nursing <input type="checkbox"/> Hospice	
Is this a carve-out plan?				
Is this a managed plan?				
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 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: _____

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Insured last name (if different)	Suffix	First name	MI	D.O.B
Patient relationship to insured: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent <input type="checkbox"/> 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	<input type="checkbox"/> HMO <input type="checkbox"/> PPO	<input type="checkbox"/> POS <input type="checkbox"/> Workmen's Comp	<input type="checkbox"/> LOP <input type="checkbox"/> Medicare	<input type="checkbox"/> Medicaid <input type="checkbox"/> PIP

CLINIC USE ONLY	Is Physical Therapy Care a network provider?		<input type="checkbox"/> Yes	<input type="checkbox"/> 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 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.

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Date: _____