Insurance Information and Verification of Benefits

Name ____________________________________ Date of Birth: ____________ Phone: __________________________

Injury / Diagnosis____

ICD –9 Codes ___________ ___________ ___________ ___________ **PT Evaluation Date:** ________________

Date of Onset? Date of the accident or first time you noticed the problem? ___________________________
Can be a month or year if chronic condition with gradual onset.

Primary Health Insurance:____ Payor ID __________________

Address: (send claims to) ____

Insurance Phone # ____

Employer: ____

Plan Name: ____

Policy ID # ____ Group # (if listed on card) _________________________

Card Holder/Guarantor (If not the patient) _______________________________________

Relationship to Patient:______________ Cardholder's Date of Birth: _____________ SS# _________-____-_________

Deductible ___________ Deductible met this year: __________ Maximum Visits per year ___________

Coinsurance ___________ Pre-cert Required ____

Co-pay ___________ Effective date: _____________________

Benefits Verified with _________________________ **on** ____________________ **Reviewed with Patient** _________

Secondary Insurance/ Auto / Workers' Compensation (If applicable**)**____
Payor ID ______________
Address: (send claims to): ____

Insurance Phone # (_______)______________________ Contact Person / Claim Representative: _____________________

Employer ____

Plan Name____

CLAIM OR ID # ____ Group # _________________________

Card Holder (Guarantor) ____ Relationship to Patient:____________

Cardholder's Date of Birth _____________ Social Security Number _________-_________-___________

Deductible ___________ Deductible met this year: __________ Maximum Visits per year ___________

Coinsurance ___________ Pre-cert Required ____

Co-pay ___________ Effective date: _____________________

Claim Maximum __________

Benefits Verified with _________________________ **on** ____________________ **Reviewed with Patient** _________