Insurance Verification Form for OT /PT /ST

Date: _____

Patient: _____ DOB: _____

Primary Insurance Company: _____
Phone#:_____
Policy Holder's name:_____
Policy #:_____ Group #:_____

Policy Period: from _____ to _____

Out of Network Benefits YES NO IF no, is there a process to complete to be approved at the In Network rate?_____

Deductible amount: _____ Amount Met:_____

Office Co-Pay amount: _____ Home visit co-pay amount: _____
(Notify insurance home visits will be billed using office procedure codes)

Co-Insurance amount: _____

Max visits Per Policy Period: _____ How many have been used?_____
(OT/PT combined)/ ST

Pre– Certification Required YES NO Fax number to request pre-cert and information to be sent? _____

Pre-certification reference code: _____
Authorization effective dates: from _____ to _____
Total visits approved: _____

Does Referring Physician need to make referral YES NO

Secondary Insurance Company: _____