

SIMPLY RESULTS PHYSICAL THERAPY
Patient Insurance Benefits Verification Questionnaire

PATIENT NAME: _____ DATE OF BIRTH: _____

NAME OF INSURANCE PROVIDER: _____

MEMBER ID#: _____ GROUP #: _____ Primary/Secondary (**Circle One**)

When calling your insurance, please address yourself as a patient of "Simply Results Physical Therapy" and ask the following questions, as written:

- 1) Does my plan cover **Physical Therapy Treatment**? Yes No
- 2) Is my Insurance **In-Network**? Yes No
- 3) Does my Insurance have a DEDUCTIBLE for *Physical Therapy* Treatment? \$ _____
 - a. What is the calendar year for this? Jan-Dec / July-June / Other: _____
 - b. If some of the DEDUCTIBLE has been met, what is amount is remaining? \$ _____
- 4) How many **visits** per year does my Insurance pay? _____
 - a. What is the calendar year for this? Jan-Dec / July-June / Other: _____
 - b. How many **visits** are covered before authorization is required? _____
- 5) If authorization is required, how do I get that authorization for physical therapy?
Circle One: Doctor Patient Physical Therapist Other _____
- 6) Do I have a **copayment** per visit? \$ _____ or a **coinsurance** percentage split _____%
- 7) Do I have any provisions for Telehealth? _____

Representative Name: _____

Call Reference Number # _____

Physical Therapy CODES THAT MIGHT BE BILLED:

| | |
|---------------------------------|--|
| 97014 E-Stimulation / TENS | 97161, 97162, 97163 Evaluation |
| 97035 Application of Ultrasound | 97164 Re-Evaluation |
| 97140 Manual Therapy | 97530 Therapeutic activities |
| 97110 Therapeutic Exercise | 97535 Self-care/home management training |
| 97112 Neuromuscular reeducation | 90912, 90913 or 90901 Biofeedback |
| 97116 Gait Training | |

I acknowledge that I have contacted my Insurance Company and have received answers to the above questions by speaking with the insurance representative named above.

X _____

Patient Signature

Date

I acknowledge that I DID NOT contact my Insurance Company regarding the above questions and agree to be responsible for any portion of charges that my Insurance Company does not pay.

X _____

Patient Signature

Date