

INSURANCE VERIFICATION FORM

Please take a few minutes to contact your Insurance Carrier and obtain the following information. Please note that benefits quoted are not a guarantee of payment.

Name of primary insurance carrier: _____

Name of Subscriber: _____

MY BENEFITS:

Please check to make sure that your treatments will be covered by your insurance plan by answering the following questions.

I/My child would like to receive Occupational/Physical/Speech Therapy. (Circle all that apply)

My insurance plan covers the therapy or combination of therapies circled above Yes__ No__

The specific condition for which I/my child would like to be treated for is covered Yes__ No__

Does your insurance plan require a physician referral? Yes__ No__

Do you need Pre-Authorization before treatment? Yes__ No__

Check one box below and complete the blank space:

- I have a limit of \$_____ or # of visits _____
(Specify # of visits)
- Do not have a dollar or visit limit

My benefits are covered yearly from _____ through _____
(MM-DD-YY) (MM-DD-YY)

My calendar year deductible is: \$_____ This benefit is subject to my deductible (Y/N)

My co-payment for each visit is: \$_____

MY INSURANCE IS:

- Contracted with the provider/providers office: Kimberly Alquist of Bothell Pediatric and Hand Therapy
- Insurance is not contracted

I spoke with _____ of my insurance carrier on _____. Their contact number is _____ (IF AVAILABLE).

We at Bothell Pediatric and Hand Therapy hope this information helped you to better understand your insurance plan, and the information was beneficial for you. The information that you obtained will serve to improve our understanding of your coverage and assist us in submitting claims and proper reimbursement.