

Patient Verification Questionnaire

Before you call your insurance company, have the following ready:

1. Your name (as on your card); _____ Birth Date: _____
2. Subscriber Name (Spouse/parent): _____ Birth Date: _____
3. ID Number: _____ Group Number: _____
4. Diagnosis (if possible/will be on prescription from doctor): _____

When you call your insurance company say:

1. "I am calling to verify my insurance for physical therapy in an **OFFICE** setting." Or Place of service 11
2. Note the date/time and person you are speaking with: _____
3. If they ask where you are having your therapy: Gainesville Physical Therapy & Wellness, LLC

They will tell you:

1. Effective date of insurance: _____
2. Current deductible: _____
3. Co-Pay: _____ Co-insurance: _____ % insurance will pay/ _____ % your responsibility
4. Number of visits allowed: _____ per time limit _____ # visits used _____
5. Yearly/lifetime maximum _____
6. Combined with Speech Therapy? Occupational Therapy? Chiropractic? Massage?
7. Out of pocket maximum; _____ then claims paid at _____ %
8. Is pre-certification or prior authorization for treatment required? ___No ___Yes
 - a. Phone number to call for authorization: _(_____)_____
9. Is authorization required at any time? _____
10. Do you require a referral from your physician? ___ No ___ Yes