GAINESVILLE PHYSICAL THERAPY & Wellness

Gainesville Physical Therapy & Wellness
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Patient Insurance 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/occupational 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 year: _____ # of visits used_____
5. Combined with Speech Therapy? Occupational Therapy? Chiropractic? Massage?
6. Is pre-certification or prior authorization for PT/OT required? _____ No _____ Yes
    a. Phone number to call for authorization: ( ) _____
7. Is authorization required at any time? _____
8. Do you require a referral from your physician? _____ No _____ Yes