



## Insurance Worksheet

This form is to help you understand your insurance plan and benefit coverage for physical therapy services. Please see your original insurance contract for full benefit explanation. You are ultimately responsible for all costs of physical therapy service.

Client Name \_\_\_\_\_ Insurance Plan Name \_\_\_\_\_

ID # \_\_\_\_\_ Group/Policy # \_\_\_\_\_

Name of Insured (if not self) \_\_\_\_\_ Insured DOB \_\_\_\_\_

Relationship to Insured \_\_\_\_\_ Insured Employer \_\_\_\_\_

Signature of Insured \_\_\_\_\_ Date \_\_\_\_\_

Is there another Health Benefit Plan? Y N

If yes: Second Insurance Plan Name \_\_\_\_\_

Who carries the second plan? \_\_\_\_\_

This person's date of birth \_\_\_\_\_

Policy &/or Group number \_\_\_\_\_

Employer \_\_\_\_\_

### Call Your Insurance Company with the following questions:

Does my plan cover outpatient out-of-network physical therapy? Y N

Do I need a physician referral for physical therapy services? Y N

If yes, Is a referral from a chiropractor acceptable? Y N

What percentage will insurance cover out-of-network? \_\_\_\_\_%

What is my co-pay or co-insurance? \$\_\_\_\_\_

What is my out-of-network deductible? \$\_\_\_\_\_

How much have I met? \$\_\_\_\_\_

How many sessions are allowed per year? \_\_\_\_\_

How many units per session are allowed? \_\_\_\_\_

To what address should claims be sent?

Is there any other information?

Please use this completed worksheet to assist you in preparing your insurance claim form.