Patient Name: _____

Patient DOB: _____

Patient Account Number: _____

Patient Benefit Summary

Co-pays and any outstanding balances are due at the time of service. It is recommended and encouraged that Patients contact their insurance carrier to validate their benefits. Verification of coverage is not a guarantee of benefits or payment. Actual plan coverage and benefit payments are determined when a claim is received by your insurance company. Therefore, the information below is an estimate of your coverage and in no way a guarantee of your out-of-pocket responsibility.

PRIMARY INSURANCE VERIFICATION

Primary Insurance Plan Name: _____ Insured Name: _____ Insured DOB: _____

According to: _____ on _____ your benefits include the following:

Effective Date: _____ When does Insurance Calendar Year Begin/End: _____/_____

Annual Deductible: $_____ Deductible met: $_____ Deductible Remaining: $_____

Out Of Pocket Maximum: $_____ Out Of Pocket Maximum met: $_____

Co-Insurance/Copay Per Visit: _____ Number of Physical Therapy Visits Allowed per Year: _____

Is Preauthorization required: Y N If yes, Authorization Number: _____

Number of Visits Authorized: _____ Authorized Dates from: _____ to _____

Is a PCP Referral Required: Y N If yes, who is PCP? _____

Therapy Cap: Y N If yes, Therapy Cap Amount: $_____ Therapy Cap Amount Met: $_____

SECONDARY INSURANCE VERIFICATION

Primary Insurance Plan Name: _____ Insured Name: _____ Insured DOB: _____

According to: _____ on _____ your benefits include the following:

Effective Date: _____ When does Insurance Calendar Year Begin/End: _____/_____

Annual Deductible: $_____ Deductible met: $_____ Deductible Remaining: $_____

Out Of Pocket Maximum: $_____ Out Of Pocket Maximum met: $_____

Co-Insurance/Copay Per Visit: _____ Number of Physical Therapy Visits Allowed per Year:

_____

Is Preauthorization required: Y N If yes, Authorization Number: _____

Number of Visits Authorized: _____ Authorized Dates from: _____ to _____

Is a PCP Referral Required: Y N If yes, who is PCP? _____

WORKER'S COMPENSATION ONLY

By signing below, I authorize **BORDER THERAPY SERVICES** to contact my employer to obtain authorization that this is a workers compensation claim and to obtain a job description and/or a list of essential job functions to further assist in my rehabilitation process. Should my employer not approve this as a workers compensation benefit, I will supply my personal medical insurance information and authorize filing of my claims with my insurance company. I further understand, if for some reason my insurance carrier does not pay for services rendered, I will be responsible for paying.

_____ _____

Patient/Guardian/Responsible Party Date

LIEN ACCOUNTS ONLY

I understand that holding an account due to a lien is a courtesy. By signing below, I authorize my medical insurance to be billed if the lien has not provided prompt payment and/or the attorney letter instructs us to bill the insurance. Prompt pay is defined as 120 days for Medicare plans. I understand that if my medical insurance puts an amount to my responsibility (such as deductible, co-pay or co-insurance) that I will be responsible for those amounts potentially prior to the lien resolution.

_____ _____

Patient/Guardian/Responsible Party Date

NO-FAULT AUTO ACCOUNTS ONLY

I understand that in many situations medical insurance is primary to no-fault auto insurance and, if applicable, have done my best to ensure I have provided accurate coordination of benefit information regarding which payer is primary and which is secondary. If it is determined that auto insurance is primary, I will still supply my personal medical insurance information and authorize filing of my claims with my insurance company in the event that auto denies or if I have Medicare and auto does not promptly pay for services. Prompt pay is defined as 120 days from the date of service for Medicare plans. I further understand if for some reason my insurance carrier does not pay for services rendered, I will be responsible for paying.

_____ _____

Patient/Guardian/Responsible Party Date

I understand that benefit verification is not a guarantee of how my insurance will process my claims. I understand that my insurance benefits are my responsibility and that I need to contact my insurance company at the number on the back of the card for confirmation of my out-of-pocket costs associated with physical therapy.

Please initial: ☐

I have read and fully understand the above information and my insurance benefits.

_____ _____

Patient/Guardian/Responsible Party Date

_____ _____

Representative Signature Date

Revised: 3/20/2019