



INSURANCE VERIFICATION FORM

For your information, please take a few minutes to contact your insurance company to obtain the following information. Please note that benefits quoted are not a guarantee of payment.

Name of Insurance Company _____

Name of Subscriber _____ Date of Birth of Subscriber _____

Policy # _____ Group # _____

Subscriber Employer, if applicable _____

MY BENEFITS:

We employ both Physical and Occupational Therapists. Before your first appointment, please check to make sure that your treatments will be covered by your insurance plan by asking the following questions:

I have been referred to Highline/Southwest Hand Therapy for treatment of

Your injury or condition

- ✓ Does my insurance plan require a Primary Care Physician referral?
 Yes No
- ✓ Does my insurance plan require **pre-authorization** before treatment?
 Yes No
- ✓ Will my treatment be covered if provided by an Occupational Therapist?
 Yes No

What are my benefits?: _____

Copay _____ Deductible _____ Maximum _____

- ✓ Will my treatment be covered if provided by a Physical Therapist?
 Yes No
- ✓ Do I need a Physician therapy prescription/referral to see a Physical Therapist? Yes No

What are my benefits?: _____

Copay _____ Deductible _____ Maximum _____

I spoke with _____ of my insurance company on _____
(Date)