Insurance Verification/Authorization

Date:_____

Patient:_____DOB:_____

SS#_____

Name of Policy Holder(if not patient)_____

Insurance Co:_____

ID#_____Group#_____

Mailing Address:_____

Phone#_____

Spoke to:_____Effective Date:_____

Type of Insurance:W/C_____HMO_____PPO_____

Deduct$_____Deduct met $_____Out of Pocket $_____ Met_____

Paid at%_____Copay amount_____

Are out of network benefits available? Yes No

Is precert or auth needed? Yes No

Limitations for therapy:_____

Workers Compensation:

Adjuster/Case Manager:_____

Work Comp Carrier & Mailing Address for claims:_____

Personal Injury:

Attorney:_____Phone_____

Address:_____Fax_____

PI Carrier:_____Phone_____

Address:_____DOA:_____