

Payment Verification Worksheet for Patient _____ Date _____

Primary insurance Name _____ Phone Number () _____

Address to send claims: _____

Date of Eligibility	Copay \$ OR Coinsurance %	Deductible \$	Met \$	Limits to therapy
Notes				
Name of Representative			ID of Representative:	

Questions to ask your insurance company regarding your Physical Therapy Benefits.

1. Phone the member service number on the back of your card
2. When you get a representative, tell them you are looking to get your benefits quoted for physical therapy in an *office* setting
3. Do I have a Co-pay or Co-insurance?
 - a. If Co-Pay: what is the dollar amount.
 - b. If Co-Insurance: what is the percentage
4. What is my deductible amount?
5. How much of the deductible has been met as of today?
6. Are there limits to my therapy benefits? If yes, what are they?

Please get the name and ID number of the Representative that quoted you these benefits

