Patient Referral / Insurance Verification Form PT / OT / CHT

Date:_____ Splint / Benefits

How did you hear about us: : EMAIL / FB / FF / MD / WEB / WKSP / Newsletter Other:_____Spanish / English

Patient's Name:_____M__F__ Guardian:_____

DOB:_____ Contact:**(H)**_____**(M)**_____Script: Y N Date:_____

Ref Phys:_____PCP:_____#_____PCP/ Ortho

Diagnosis:_____ ICD10:_____

Post Surgical: Y N Date:_____ CVA: Y N Date:_____

Primary:_____plan type:_____ID:_____Ph #:_____

Secondary:_____ID:_____Ph #:_____

Group #: _____ Home Address:_____

Email Address: _____ Marital Status: M S D W

Sch Claim Form: Y or N School: _____DOA: _____

Have you had Physical and/or Occupational and/or Speech Therapy within the past 12 months? Y N

Mo/Yr:_____Condition:_____Approx # of visits used: _____

Have you received Home Health Care or Hospice Services within the past 12 months? Y N

Name of Home Health Agency: _____ **Phone#:** _____

Employee_____

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Discharge Date: _____ **Spoke with:** _____

Are you being treated for injuries sustained from an **Auto Accident**, a **Slip and Fall** OR **Work Related Injury**? Y N

Were you referred by the Athletic Program in a County school? Y whom: _____ N

Appointment: Date: _____ **Time:** _____ **Therapist:** _____

_____

_____

_____

Standard Insurance:

Date: _____

Insurance Rep Name: _____ Plan Type: _____ Effective Date: _____

Co-pay Y N Amt: $ _____ DED Y N Amt: $ _____ Met Y N $ _____

Co-insurance Y N Amt: _____ / _____ OOP Y N Amt: $ _____ Met Y N $ _____

Visit Limitations: _____ How many used? _____

Modalities per day: _____ Is Authorization/ Referral Required? Y N Auth #: _____

Auth EFF date: _____ EXP date: _____ Provider # Auth is for: _____

MC: Is Part B DED met? Y N PT CAP remaining: $ _____ OT CAP remaining: $ _____

MC Secondaries: Cover Part B DED? Y N Cover co-ins after MC? Y N

Claims mailing address: _____ Pre existing apply: _____

Home Health Care: _____ Hospice: _____ Ref #: _____

Worker's Comp:

Insurance Co: _____

Claim #: _____ DOI: _____

Claim Adjuster: _____

Direct Ph #: _____

Adjuster Fax #: _____

Authorized Visits: _____

Claims mailing address: _____

Auto Accident:

Insurance Co. _____

Claim #: _____ DOA: _____

Pip Adjuster: _____

Direct Ph#: _____

Basic PIP: Y N Deductible: Y N $ _____

Med Pay: Y N Exhausted: Y N

Employee_____