Patient Referral / Insurance Verification Form PT / OT / CHT

Date:_______________ NE WEST EAST HAND SPECIALTY 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/ HCD

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#:**_______________________
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

Appointment: Date:_____________________**Time:**_____________________**Therapist:**______________________

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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_________