Please call your insurance provider to verify your insurance coverage for physical therapy prior to your first visit. Use this form to guide your call. This information will help you understand your insurance benefits.

Name:_____Date:_____

Insurance plan name or program name:_____

Member ID#:_____Group number: _____

Customer service phone number (with area code):_____

Name of customer service representative:_____

Insurance claim address: _____

Date eligibility began: _____

Deductible: $_____ Co-pay: $_____ Co-insurance*: $_____

Co-insurance* maximum or out of pocket maximum: _____

* Co-insurance is the amount not covered by your insurance policy.
The co-insurance is the responsibility of the patient.

Maximum allowable benefit for physical therapy: $ _____ or # of visits_____

Remaining $_____ or # of visits _____ for current year as of _____

Is my physical therapist, Susan Grote, a preferred provider for my plan? Yes _____ No _____

If Insight Physical Therapy and Yoga is NOT a provider for the plan, what is the benefit coverage for out of network physical therapy? (i.e. 60%, 80%) _____

Does this plan require a prescription or referral from my doctor for PT? Yes _____ No ____

Does this insurance plan require pre-authorization for PT services? Yes _____ No _____