Date / Time:	Patient Name:
Insurance Company:	Phone:
Contacted:	
Member Name:	Member DOB:
Member ID:	Group #:
Patient DOB:	Relation to Member:

Policy Effective Date:	Term/Renewal Date:
In Network? Y ◯ N ◯	Pre-Cert? Y ◯ N ◯
Deductible (Amount your plan specifies as your intial responsibility):	
Amount Met to Date:	
Co-Pay per visit (Amount you will pay for each visit separate from deductible):	
% Insurance / % Patient Responsbility (percentage your plan pays/you pay): /	
Authorization #	
Authorization Begin Date:	End Date:
Approved # of Visits:	Is there $ limit per year?
Is Insurance Primary? Y ◯ N ◯	
Mail Claims to:	
Can claims be electronically billed? Y ◯ N ◯	Payor ID #:

Comments:
Verfied: Date:

Some durable medical equipment such as foot orthotics, braces, and supplies such as electrodes and various pieces of exercise equipment for the patient to use at home are generally not covered. If these items are needed, they will become your responsibility. Please feel free to ask questions regarding this statement. I have read the insurance verification and I understand these benefits are not guaranteed. They are an estimate from my insurance company. My co-payments are due at the time of service and my percentage of financial responsiblity is due at the end of each week I am treated (if applicable). If I owe more than the insurance company originally quoted, I will be responsible for that amount. If I over-pay the bill, I will reimbursed the amount that I overpaid immediately.

Signed:_____ Date: _____