INSURANCE VERIFICATION

Patient:_____ Insured:_____

Insured's Employer:_____ Insured's SSN:_____

Patient DOB:_____/_____/_____ Insured DOB:_____/_____/_____ Spouse DOB:_____/_____/_____

Patient's Complaint/Diagnosis: _____ Relations to Insured: ❏Self ❏Spouse ❏Child ❏Other

Insurance Company:_____ Phone:(_____) _____-_____

Mail Claims to:_____ Fax:(_____) _____-_____

ID #:_____ Group #:_____ Effective Date:_____

"Hi, this is (_____). I'd like to verify OUTPATIENT BENEFITS for a patient."

"We do various types of service. I'd like to start with physical therapy benefits."

Date of Verification:_____/_____/_____ Time:_____ AM/PM Insurance Rep Name:_____

GENERAL INFORMATION:

We are: ❏IN-Network ❏OUT-of-Network   Effective Date:_____

Policy Self-Funded?: ❏Yes ❏No   Pre-Certification?: ❏Yes ❏No   Referral Needed?: ❏Yes ❏No

Deductible: ❏Yes ❏No   ❏Calendar ❏Fiscal: Begins on _____

Individual: IN-Network: $_____ OUT-Network: $_____ Met?: ❏Yes ❏No Remaining?: $_____

Family: IN-Network: $_____ OUT-Network: $_____ Met?: ❏Yes ❏No Remaining?: $_____

Co-Pay: $_____   Co-Insurance: _____%   Out-of-Pocket (Met/Remaining): $_____/_____

Pre-existing Condition Clause?: ❏Yes ❏No   Details, expires when?_____

Do We Need to Bill for Non-Covered Services?: ❏Yes ❏No   Is There Accident Rider Coverage?: ❏Yes ❏No

SPECIFIC COVERAGE QUESTIONS:

Evaluation and Management: (99201-99205, 99211-99215)

    Limitations:_____

Physical Therapy: (97535, 97110, 97012, 97014, 97112, 97530)

    Limitations:_____

    Visit Limit:_____ ❏/year ❏/condition   Max $/visit: $_____ $Max:_____ ❏/year ❏/condition

    Specific non-covered procedures:_____

    Time Rule?: ❏CMS Policy ("8-minute rule") ❏AMA Policy (15-minute increments) ❏No Preference ❏Other:

Diagnostic Services:

    Any Additional Deductible?: ❏Yes ❏No   Amount: $_____

    X-Ray Limitations:_____

    Orthotic Management (97760), Orthotic Check Out (97762)?: ❏Yes ❏No

    Custom-molded orthotics (L3020)?: ❏Yes ❏No   Pre-Cert?: ❏Yes ❏No   Referral Needed?: ❏Yes ❏No

    Orthotic Limitations:_____

Chiropractic: (98940, 98941, 98942, 98943)

    Limitations:_____

    Visit Limit:_____ ❏/year ❏/condition   Max $/visit: $_____ $Max:_____ ❏/year ❏/condition

ACCESS GUIDELINES:

"Does it matter what provider is performing the service as long as they are a licensed provider in Indiana?" ❏Yes ❏No

If answer is 'no' → End Call.   *If answer is 'yes' then ask* → "Does an MD have access?" ❏Yes ❏No

If answer is 'no' → End Call.   *If answer is 'yes' then ask* → "Is this policy governed by state statutes?" ❏Yes ❏No

If answer is 'no' → End Call.   *If answer is 'yes' then they are violating the "Provider Non-Discrimination Law".*

Ask for a copy of the "Summary Plan Description".