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Insurance Verification

With insurance card available, contact customer service with the following information:

✎ Name of Policy Holder, Policy/Group/Subscriber #'s, Social Security and Birth date of Policy Holder and Patient

✎ Name of person verifying coverage at ins. Company: _____

✎ Details of Policy: Out of Network benefits for Outpatient Occupational Therapy: **Yes/No.**

If No, is there an appeals process for therapy services not available within the network?

If Yes, What is the Out of Network Deductible and amount met:

What is % coverage after deductible is met: _____

What is the maximum Out of Pocket Expense for patient: _____

Is there a limitation on # of visits, \$ per visit or \$ limit per year:

Is a prescription required: _____

Is pre-certification required: _____

*Primary physician's office will have to do pre-cert., if needed.

Any other information that might be helpful?