SIMPLY RESULTS PHYSICAL THERAPY
Patient Insurance Benefits Verification Questionnaire

PATIENT NAME: ______________________________ DATE OF BIRTH: _____________
NAME OF INSURANCE PROVIDER:____
MEMBER ID#: ________________ GROUP #:_____________ Primary/Secondary **(Circle One)**

When calling your insurance, please address yourself as a patient of "Simply Results Physical Therapy" and ask the following questions, as written:

1) Does my plan cover **Physical Therapy Treatment?** ☐ Yes ☐ No

2) Is my Insurance **In-Network?** ☐ Yes ☐ No

3) Does my Insurance have a DEDUCTIBLE for *Physical Therapy* Treatment? $ ___________
a. What is the calendar year for this? Jan-Dec / July-June / Other:
b. If some of the DEDUCTIBLE has been met, what is amount is remaining? $ ____________

4) How many **visits** per year does my Insurance pay? _________
a. What is the calendar year for this? Jan-Dec / July-June / Other:
b. How many **visits** are covered before authorization is required?______

5) If authorization is required, how do I get that authorization for physical therapy?
Circle One: Doctor Patient Physical Therapist Other___________

6) Do I have a **copayment** per visit? $________ or a **coinsurance** percentage split _______%

7) Do I have any provisions for Telehealth?_______________________________________

Representative Name: ____
Call Reference Number #____

Physical Therapy CODES THAT MIGHT BE BILLED:

97014 E-Stimulation / TENS
97035 Application of Ultrasound
97140 Manual Therapy
97110 Therapeutic Exercise
97112 Neuromuscular reeducation
97116 Gait Training
97161, 97162, 97163 Evaluation
97164 Re-Evaluation
97530 Therapeutic activities
97535 Self-care/home management training
90912, 90913 or 90901 Biofeedback
97537 Community /Work Integration
97750 Physical PerformanceTest with Report

◯ I acknowledge that I have contacted my Insurance Company and have received answers to the above questions by speaking with the insurance representative named above.

X ____
Patient Signature Date

◯ I acknowledge that I DID NOT contact my Insurance Company regarding the above questions and agree to be responsible for any portion of charges that my Insurance Company does not pay.

X ____
Patient Signature Date