

QUESTIONS TO ASK YOUR INSURANCE COMPANY

Contact Person/Reference #: _____ Date of Call: _____

Does this policy and benefits start over each January or at a different date? _____

Benefits are covered yearly from: _____ through: _____

Is my physical therapy clinic **in-network**? Yes ☐ No ☐

Is there a pre-existing waiting period for this plan? Yes ☐ No ☐ Date: _____

How does the pre-existing waiting period affect me: _____

Is Physical therapy subject to a **deductible**? Yes ☐ No ☐

How much is this deductible? **In-network:** _____ **Out of Network:** _____

How much of it has been met? _____

What percentage of the allowable charge is **paid by insurance**?

In-network: _____ **Out of network:** _____

What percentage of allowable charge is **my responsibility**?

In-Network: _____ **Out of network:** _____

Is there a **co-pay**? Yes ☐ No ☐ How much? _____

Are there **limits** to these **Physical Therapy benefits**? Yes ☐ No ☐

Number of Visits: _____ Dollar Amount: _____

Have any benefits been used this year? Yes ☐ No ☐

Number of Visits: _____ Dollar Amount: _____

Are any of the following required for physical therapy to be covered?

Prior Authorization ☐ Pre-certification ☐ Referral ☐

How do I obtain prior authorization or pre-certification: _____

We recommend saving this form for future reference as documentation of the benefit information provided by your insurance company.