PATIENT INSURANCE VERICATION QUESTIONNAIRE

HealthWELL verifies your insurance for you and provides this information at your first visit. Should you wish to confirm our findings, this Verification Questionnaire is designed to help you.

Before you call your insurance company, have ready:

Your Name (as on your card):________________________________ Birthdate:____________________

Subscriber Name (spouse/parent):____________________________ Birthdate:____________________

ID Number:____________________________ Group Number:______________________________

Diagnosis (if possible/will be on prescription from doctor):____

When you call your insurance company, say:

"I am calling to verify my insurance for physical therapy in an OFFICE setting."

Note the date / time and person you are speaking with:____

If they ask where you are having your therapy, say HealthWell Physical Therapy Group in San Francisco, CA.

They will tell you:

Effective date of insurance: ____________ Current deductible: ____________ How much of deductible has been paid?____________

Co-pay: ____________ Co-insurance: ____________ Percentage insurance will pay: ______ % Percentage your responsibility: ______ %

Number of visits allowed:__________ Per time limit:__________ # of visits used: _______ Yearly/lifetime maximum:____________

Out-of-pocket maximum:__________ Then claims paid at: ______ %

Combined with Speech Therapy? ☐ Yes ☐ No

Occupational Therapy? ☐ Yes ☐ No

Chiropractic? ☐ Yes ☐ No

Is pre-certification or prior authorization for treatment required? ☐ Yes ☐ No

Phone number to call for authorization?______________________________

Is authorization required at any time?______________________________

Do you require a referral from your physician? ☐ Yes ☐ No

Do you cover Telehealth services for physical therapy? ☐ Yes ☐ No

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