BENEFITS EXPLANATION

NAME OF PATIENT: ____________________ DATE: ____________

PATIENT IS: ☐ POLICY HOLDER ☐ OTHER ____________________

NAME OF POLICY HOLDER ____________________ PHONE # ____________

SS# ____________ DOB ____________ ZIP CODE ____________

INSURANCE COMPANY (PRIMARY):

NAME OF POLICY HOLDER: ____________________

SS#: ____________ DOB: ____________

TYPE OF INSURANCE: PPO____ HMO____ MEDICARE____

MEDICAID____ WORKER'S COMP____ LIEN____ OTHER ____________

COMPANY NAME: ____________________

CONTACT PERSON: ____________________

PHONE #: ____________ FAX: ____________

PLAN / PROGRAM NAME: ____________________

MEMBERSHIP #: ____________________

GROUP #: ____________________

OTHER #: ____________________

EFFECTIVE DATE OF COVERAGE: ____________________

☐ IN-NETWORK BENEFITS ________ % YOU COVER ________ %

DEDUCTIBLE: $ ________ . MET: $ ____________ AS OF___/___/___

CO-PAYMENT: ☐ YES ☐ NO AMOUNT: $ ____________

____

____

☐ OUT-OF-NETWORK BENEFITS ________ % YOU COVER ________ %

DEDUCTIBLE: $ ________ . MET: $ ____________ AS OF___/___/___

CO-PAYMENT: ☐ YES ☐ NO AMOUNT: $ ____________

____

____

REFERRAL (PRESCRIPTION) NEEDED: ☐ YES ☐ NO

PRE-CERTIFICATION NEEDED: ☐ YES ☐ NO

AUTHORIZATION #: ____________________

# of treatments authorized ____________ through___/___/___

Requirements for continuation:

____

____

MEDICAL NECESSITY: ☐ YES ☐ NO DAILY NOTES REQ'D: ☐ YES ☐ NO

BILLING ADDRESS:

____

____

____

____

INSURANCE COMPANY (SECONDARY):

NAME OF POLICY HOLDER: ____________________

SS#: ____________ DOB: ____________

TYPE OF INSURANCE: PPO____ HMO____ MEDICARE____

MEDICAID____ WORKER'S COMP____ LIEN____ OTHER ____________

COMPANY NAME: ____________________

CONTACT PERSON: ____________________

PHONE #: ____________ FAX: ____________

PLAN / PROGRAM NAME: ____________________

MEMBERSHIP #: ____________________

GROUP #: ____________________

OTHER #: ____________________

EFFECTIVE DATE OF COVERAGE: ____________________

☐ IN-NETWORK BENEFITS ________ % YOU COVER ________ %

DEDUCTIBLE: $ ________ . MET: $ ____________ AS OF___/___/___

CO-PAYMENT: ☐ YES ☐ NO AMOUNT: $ ____________

____

____

☐ OUT-OF-NETWORK BENEFITS ________ % YOU COVER ________ %

DEDUCTIBLE: $ ________ . MET: $ ____________ AS OF___/___/___

CO-PAYMENT: ☐ YES ☐ NO AMOUNT: $ ____________

____

____

REFERRAL (PRESCRIPTION) NEEDED: ☐ YES ☐ NO

PRE-CERTIFICATION NEEDED: ☐ YES ☐ NO

AUTHORIZATION #: ____________________

# of treatments authorized ____________ through___/___/___

Requirements for continuation:

____

____

MEDICAL NECESSITY: ☐ YES ☐ NO DAILY NOTES REQ'D: ☐ YES ☐ NO

BILLING ADDRESS:

____

____

____

____

Note: This is for estimation only; it is not a binding contract. For questions please call your insurance representative.

ERIC D. BRUMMEL, PT
SVASSAMA
237 North Summit Avenue • Prescott, AZ 86301
(928) 445-5639 • Fax (928) 442-0031