

Provider \_\_\_\_\_

# BILLING INFORMATION

Patient Name \_\_\_\_\_ Date \_\_\_\_\_

Date of Injury \_\_\_\_\_ ID#/DOB \_\_\_\_\_

## Billing Policy

Our office is set up to receive direct payment from insurance companies. For the best chance of reimbursement from your insurance carrier, we ask that you:

- Contact your insurance company to determine your manual therapy coverage and provider stipulations. Coverage depends on your insurance company and the specific plan you have chosen. We have provided a list of questions for you to ask your insurance representative or attorney that will help determine your eligibility for our billing service.
- You will need a current prescription for manual therapy from a primary health care provider, such as a physician or a chiropractor in order to submit your claim. Referrals are current for 90 days unless otherwise specified.

It is important that you understand your insurance policies in order for you to budget for your manual therapy services. You are personally responsible for all charges incurred in our office. We expect payment in full until your insurance coverage has been verified.

We realize that the completion of this form is an added burden to you as a consumer, and we thank you very much for your assistance. This completed form will provide both you and our billing department with important information regarding your manual therapy insurance benefits, and enable us to process your claim in a timely fashion.

## Patient Information

Is patient's condition related to:

- auto collision—In what state? \_\_\_\_\_
- other accident \_\_\_\_\_
- employment  illness

Patient status:  male  female

single  married/partnered  other

Patient relationship to insured

self  spouse/partner  child  other

## Insured's Information (if other than patient)

Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_ Zip \_\_\_\_\_

Phone: \_\_\_\_\_

Date of birth \_\_\_\_\_

Sex:  Male  Female

Employer's Name or School Name \_\_\_\_\_

## Insurance Information

Insurance plan name or program name: \_\_\_\_\_

Member ID#: \_\_\_\_\_ Group #: \_\_\_\_\_

Customer service phone #: \_\_\_\_\_ Date and time you called: \_\_\_\_\_

Name of customer service representative: \_\_\_\_\_

Insurance claim address: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Does the plan include a Physical Medicine and Rehabilitation benefit?  Yes  No

Who may provide the services?  Massage Therapist  Physical Therapist  Other

Is pre-authorization required?  Yes  No Who can authorize the services? \_\_\_\_\_

Is a prescription required?  Yes  No Is a referral required?  Yes  No

Who may refer?  MD  DC  ND  PT  Other \_\_\_\_\_

How often does the referral need to be updated to ensure continuous coverage? \_\_\_\_\_

Is there a Preferred Provider list for Manual Therapists?  Yes  No

Is \_\_\_\_\_ on the list?  Yes  No

**If this is a Workers' Compensation Claim, please fill out the following information:**

Who is the attending HCP? \_\_\_\_\_ Phone: \_\_\_\_\_

Claim number: \_\_\_\_\_ Date eligibility began: \_\_\_\_\_

Number of visits authorized: \_\_\_\_\_ Number of visits remaining: \_\_\_\_\_

Dates of coverage: \_\_\_\_\_ Date claim closed: \_\_\_\_\_

**If this is a Personal Injury Claim, please fill out the following information:**

PIP policy amount: \_\_\_\_\_ Dates of coverage: \_\_\_\_\_ PIP available: \_\_\_\_\_

MedPay amount: \_\_\_\_\_ Dates of coverage: \_\_\_\_\_ MedPay available: \_\_\_\_\_

Liability amount: \_\_\_\_\_ Dates of coverage: \_\_\_\_\_ Liability available: \_\_\_\_\_

Uninsured/Underinsured (UMI) policy amount: \_\_\_\_\_ UMI available: \_\_\_\_\_

Has the PIP application been received?  Yes  No

Has an attorney been consulted?  Yes  No Retained?  Yes  No

Name/Firm \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone \_\_\_\_\_ Fax \_\_\_\_\_

**If this is a Private Health Insurance Claim, please fill out the following information:**

(Or, if your Personal Injury claim defaults to secondary coverage, fill this out)

Maximum allowable benefit for Physical Medicine/Rehabilitation: \_\_\_\_\_

In network: \$ \_\_\_\_\_ # visits \_\_\_\_\_ Remaining \$ \_\_\_\_\_ # visits \_\_\_\_\_

Deductible: \$ \_\_\_\_\_ Satisfied to date: \$ \_\_\_\_\_ Co-Pay: \$ \_\_\_\_\_

Out-of-network: \$ \_\_\_\_\_ # visits \_\_\_\_\_ Remaining \$ \_\_\_\_\_ # visits \_\_\_\_\_

Deductible: \$ \_\_\_\_\_ Satisfied to date: \$ \_\_\_\_\_ Co-Insurance: \$ \_\_\_\_\_

Are these limits just for manual therapy?  Yes  No

If no, what other types of treatment do they include? \_\_\_\_\_

(i.e., chiropractic, physical therapy, occupational therapy, naturopathy, etc.)

**Assignment of Benefits**

My signature below authorizes and directs payment of medical benefits for services billed to my health care provider: \_\_\_\_\_

**Release of Medical Records**

My signature below authorizes the release of my medical records including intake forms, chart notes, reports, and billing statements to my attorneys, health care providers, and insurance case managers, for the purpose of processing my claims. (I will inform my practitioner immediately upon signing any exclusive Release of Medical Records with my attorney.)

**Financial Responsibility**

It is my responsibility to pay for all services provided. In the event that my insurance company denies payment or makes a partial payment, I agree to be and remain responsible for the balance. It is also my understanding and agreement that if you have contracted with my insurance company at a discount rate and the agreed-upon fee has been satisfied, the balance owed on those specific visits will be waived.

Signature \_\_\_\_\_ Date \_\_\_\_\_