

BILLING INFORMATION REQUEST FORM

In order to fully understand physical therapy coverage under your insurance plan, we have developed this questionnaire to be completed PRIOR to your first visit.

NOTE: You are responsible for obtaining this information from your insurance company. We thank you for your assistance in this matter.

- Insurance plan name or program name: _____
- Member ID number: _____ Group number: _____
- Customer Service phone number (w/area code) _____
- Name of customer service representative: _____
- Insurance claim address: _____
- Date eligibility began: _____
- Deductible: \$ _____ Co-pay: \$ _____ Co-insurance: \$ _____
- Maximum allowable benefit for physical therapy: \$ _____ # visits _____
- Remaining \$ _____ # visits _____ for current year as of _____
- Does this plan require a *referral* from the *primary care physician* to Movement Systems Physical Therapy, P.S. for payment of services? YES/NO

OR, *IS A PRESCRIPTION REQUIRED?* YES/NO (NOTE THAT A PRESCRIPTION AND REFERRAL ARE NOT ONE AND THE SAME).

- How often does the referral/prescription need to be updated to ensure continuous coverage? (i.e., every 2 weeks, every month, every three months, etc.) _____
- If your company is an HMO or PPO, and we are NOT a provider for the plan, what is the benefit coverage for Movement Systems Physical Therapy, P.S.? (i.e., 60%, 80%, etc.).

We realize that 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 physical therapy insurance benefits, and enable us to process your claim in a timely basis.