Insurance Coverage and Benefits WORK SHEET

PLEASE complete this form PRIOR to your initial appointment

To ensure that you are fully protected, you are required to contact your insurance agent to determine benefits and eligibility for Physical Therapy prior to your visit. Please call the phone number listed on the back of your insurance card and inform your insurance carrier that you are about to begin Physical Therapy. You will need to provide your name, date of birth and insurance ID#. You will also need to ask a series of questions in order to understand any restrictions or limitations they may have in place concerning your eligibility and /or benefits pertaining to Physical Therapy. We must receive this form completed **before you are seen**!

For your commercial **(non-traditional Medicare or Medicaid)** insurance, please ask the following questions:

- Is Orion Physical Therapy Specialists, Tax Id# 030429134 at 105 Sugar Camp Circle, Ste. 221 in Dayton, Ohio 45409 an **"IN-NETWORK"** provider? **Answer: Yes No**
- If Orion Physical Therapy is **not** "**IN-NETWORK**" do I have "**OUT-OF-NETWORK**" **benefits?** **Answer: Yes No**
- Is **Prior Authorization** for Physical Therapy required? **Answer**: **Yes No**
- Prior Authorization Phone number:_____ Fax number: _____
- How many Physical Therapy v**isits** am I allowed per year? **Answer**:_____
- How many **visits** do I have **remaining**? **Answer**:_____
- When did my plan become effective? **Answer**:_____
- Are there any other limitations or restrictions I should be aware of pertaining to Physical Therapy Benefits per my plan? **Answer:**_____
- Do I have to meet an **Individual Deductible**? $_____ **Amount Remaining $** _____
- Do I have a C**opay**? $_____ per visit. My plan pays _____ **% Coinsurance**
- My **Out-of-Pocket Max** $_____ **Amount Remaining $** _____
- Is a **Referral** required per my plan? **Answer**: **Yes No**

If you have **Traditional Medicare** (your card is Red, White & Blue and the beneficiary's social security number is the ID #), and you have had any physical therapy this year at any other facilities, you must notify us. You will want to contact **Medicare part B** and inquire the **Cap $**_____ amount available to you in which physical therapy visits would be included. Please note there are restrictions and limitations.
Please provide available **$ amount** on space provided above.

---

*If your insurance denies Physical Therapy coverage and you choose to remain a patient here we do offer a S**elf-Pay Rate**.
Flat Fee is $100 for the initial evaluation and $60 for every visit thereafter.

We do require that all of the information above be completed prior to your visit; otherwise we cannot begin your treatment/evaluation. Your insurance carrier can provide all information above.

Please Print and Sign your name that you agree and understand the information provided above that you obtained from your Insurance Co.

_____ _____

Printed Name and Date: Signature: