

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 _____