



INSURANCE FORM

Health insurance policies are an agreement between you and your insurance company. To help you understand what coverage you can expect relative to outpatient therapy, simply call your insurance company and ask the following questions. Although not every area of treatment is covered on this form, it should clarify most questions, and be useful in submitting claims. The number to call should be located on the back of your insurance card. If you would like us to send a claim to your insurance company please return this completed form to our office.

Date you called your insurance company _____

Name of the person who gave you information _____

Effective date of my Policy? _____

Does my policy cover outpatient therapy?(ask about habilitative Occupational therapy and habilitative speech therapy) _____

If your insurance company requires billing codes these are the most often used codes, however this is not a comprehensive list. CPT: 97167, 97530, 97532, 92507

Diagnosis code: _____

(Be sure to specify this is developmental speech therapy not restorative)

What is my financial responsibility?

Co-Pay _____

Deductible _____ How much have I met?: _____

Co-insurance _____

Annual maximum benefit _____

Lifetime maximum benefit _____

Maximum visits per year _____ (number of visits used thus far) _____

Do I require a referral or prescription from a doctor? _____

Does my plan require Medical Necessity as an exclusion: _____

Do I require precertification or pre- authorization: _____

What number do I call to get pre-authorizations? _____

Fax number for pre-authorization request : _____

*If yes, how many visits will be pre-authorized? _____



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Very Important what is the address my provider will use to mail my claim forms?

Do I have to chose a provider within my network? _____

If we are of Out- Of- Network for you plan:

Do I have Out-of-Network benefits? _____

*If yes, what are my out-of network benefits?

Co-Pay \$ _____
Deductible \$ _____ How much have I met?: _____
Co-insurance \$ _____
Annual maximum benefit \$ _____
Lifetime maximum benefit \$ _____
Maximum visits per year _____ (number of visits used thus far) _____