Date: ____________ **Patient Name:** ______________________________________ **Patient DOB**: ___________

Insured Party: (if different from the patient)

Name: ____
First Middle Initial Last
Address: ____
Street City State Zip
Date of Birth:_______/______/______ Gender: Male or Female SSN _________________
Month Date Year
Phone#: Home _______________________ Cell _______________________Work______________________
Relationship to Patient: _______________________
Employer: ____

Insurance Information: (Office Use Only) Verification/Authorization Date:__________
Primary Insurance Company: _________________________________ Ins Claim Adj/Verifier:____________
Phone#:________________________ Fax#:_________________________
Policy Effective Date:____________
ID or Claim#:________________________ Group#:___________ Group Name: ________________________
Authorization #:_________________ # of Visits Authorized:_________ Authorization Expiration Date:______
Deductible: Single $________________Met $_________________Family $______________Met $_______________
OOP: Single $________________Met $_________________Family $______________Met $_______________
Deductible included in the OOP amount: Yes No DME: ____________________ Script: Yes No
Patient Percentage:_______________ OR Copay: _______________ Max $ Amount Allowed: _____________
# of Visits Allowed: _____________________________________ # of Visits Used: _____________________
PT Script Required: Yes No
Precertification Required: Yes No ACN Certification: Yes No Cover Re-Eval - 97164: Yes No

CPT Codes Excluded: G0283 97014 97033 97124 97035 97010 97112 97116 97530

Comments:____
____

Secondary Insurance Information: (Office Use Only)
Primary Insurance Company: _________________________________ Ins Claim Adj/Verifier: _____________
Phone#: _______________________ Fax#:_________________________
Insured Name: __________________________________ Date of Birth: _____________ Gender: M F
Policy Effective Date:____________
ID or Claim# ________________________ Group#:___________ Group Name: _______________
Deductible: Single $_______________Met $_________________Family $_______________Met $_______________
OOP: Single $_______________Met $_________________Family $_______________Met $_______________
Deductible included in the OOP amount: Yes No
Patient Percentage: ________________ OR Copay:_______________ Max $ Amount Allowed: ___________
# of Visits Allowed: _________________________________ # of Visits Used:__________
PT Script Required: Yes No

CPT Codes Excluded: G0283 97014 97016 97033 97140 97124 97762 97035 97010

Comments:____
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