# **Insurance benefit worksheet**

**PLEASE CALL YOUR INSURANCE COMPANY PRIOR TO YOUR APPOINTMENT:** Today’s reimbursement climate is in a state of constant flux. In order to assist in fully understanding your physical therapy coverage under you insurance plan, please complete this questionnaire by calling your insurance carrier before your first visit.

**Patient Name: ­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Member Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Insurance plan or program name: ­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Member ID number: ­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Customer Service phone number (with area code): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Name of customer service representative: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date eligibility began: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Deductible: $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Co-pay: $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Co-insurance: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Maximum allowable benefit for Physical Therapy: $\_\_\_\_\_\_\_\_\_\_ Massage Therapy $\_\_\_\_\_\_\_\_\_\_# of visits \_\_\_\_\_\_\_**

**Remaining $ \_\_\_\_\_\_\_\_\_\_\_\_\_ Remaining # of visits: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ for current year as of\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Does your plan require a referral or prescription for physical therapy for payment of services? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Does your plan require pre-authorization for physical and or massage therapy? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

JBJC realizes that the completion of this form is an added step for you as a consumer, and we thank you for your assistance. This completed form will provide us both with important information regarding your physical therapy insurance benefits and enable our billing department to process your claims in a timely manner.

**IMPORTANT INSURANCE INFORMATION:**

* Your deductible must be satisfied before the insurance company will pay for your treatment. You will be billed for any unsatisfied amount.
* Your co-insurance amount is the amount not covered by your insurance plan. The co-insurance amount is the patient responsibility.
* Once your claim is processed you will be billed on a monthly basis for any remaining balance that can include outstanding co-pays, co-insurance, etc.
* Be aware that prescriptions, referrals, and pre-authorizations have expiration dates and/or set visit limit. Check to be sure your paperwork has not expired prior to your first visit. Prescriptions are typically current for 90 days unless otherwise noted.
* Rehabilitation benefits can include occupational therapy, speech therapy, massage therapy, and acupuncture, depending on your insurance plan. In addition, physician and chiropractic offices can provide and bill for therapy services. These services may be paid out of the same benefit amount.
* Alaska is a direct access state for physical therapy, meaning you do not need a prescription to seek physical therapy services. Not all plans require a prescription for physical therapy to process your claim, but ALL plans do require that the services billed are **medically necessary.**  A prescription does not guarantee medical necessity for all plans. If for any reason your insurance provider denies your claim, you agree to pay any outstanding balance.