Provident Physical Therapy/ Occupational Therapy

BENEFIT REVIEW FORM

Patient's Name:_____ D.O.B _____/_____/_____

Insurance: _____ Commercial _____Medicare _____ Workers Comp _____ No-Fault

Insurance:_____

Benefits:_____
_____
_____

**********These plan benefits were obtained by a representative of your insurance plan**********

Your insurance company requires:

- Authorization for therapy treatment:☐Yes ☐No

- $_____ co-pay per visit. This payment is required at the time of your appointment as per your insurance contract.

- Deductible amount of $_____, the amount met to date $_____.

- _____% co-insurance per visit. (This is a relative percentage of the bill, which the insurance company does not cover and is the patient's responsibility. This amount may vary depending upon the different procedures performed. Once your insurance company has processed the claim they will tell us your responsibility. Please note, any plan deductibles must be met before an insurance plan will apply a co-payment/ co-insurance).

<u>Important please read:</u>

- Claims denied due to Insurance Benefit Denials or Policy Issues will be the responsibility of the patient.
- Co-Pays and Co-insurances are part of your insurance plan contract and as a provider with your insurance plan we must collect these fees. Please do not ask us to waive them that would be considered illegal.
- Payment is due at the time of services rendered. Any past due balances will be forwarded to collections; you the undersigned will be responsible to pay the balance due, accrued late fees, as well as all collections fees.
- It is your responsibility to inform us of any insurance plan changes ahead of time, failure to do so may leave you responsible for payment. May insurance plans require authorization before the visit and the plans do not do retroactive approvals.
- If you are paying privately payment is due at the time of service.

- I am filing through No-fault / Workers Compensation, however, if my benefits are not covered, I understand my commercial insurance plan will be charged for my services provided. I will make sure I provide all insurance information necessary.

I have read the above information and understand my plan benefits for Physical/ Occupational therapy. I have been given a copy of these benefits:

X_____ Date: _____/_____/_____