

**Patient Self Insurance Verification Questionnaire**

**BEFORE YOU CALL YOUR INSURANCE COMPANY, HAVE READY:**

You name (as on your card): \_\_\_\_\_ Birth Date: \_\_\_\_\_  
Subscriber Name (spouse/parent): \_\_\_\_\_ Birth Date: \_\_\_\_\_  
ID Number: \_\_\_\_\_ Group Number: \_\_\_\_\_  
Diagnosis(if possible/would be on prescription from doctor): \_\_\_\_\_

**WHEN YOU CALL YOUR INSURANCE COMPANY SAY:**

“I am calling to verify my insurance for Physical Therapy in an **OFFICE** setting”  
Note the date/time and person you are speaking with: \_\_\_\_\_  
If they ask where you are having your therapy: Physical Therapy & Wellness Institute

**THEY WILL TELL YOU:**

Effective date of insurance: \_\_\_\_\_  
Current deductible: \_\_\_\_\_ How much deductible has been met for the year: \_\_\_\_\_  
**Co-Pay:** \_\_\_\_\_ **Co-Insurance:** % Insurance will pay: \_\_\_\_\_ % Your responsible for: \_\_\_\_\_  
Number of visits allowed: \_\_\_\_\_ per time limit: \_\_\_\_\_ (days/year) # visits used: \_\_\_\_\_  
Yearly/Lifetime maximum: \_\_\_\_\_  
Combined with Speech Therapy? Occupational Therapy? Chiropractic?  
Out of pocket maximum \_\_\_\_\_ Then claims paid at \_\_\_\_\_%  
Is pre-certification or prior authorization for treatment required? Yes/No  
Phone Number to call for authorization: \_\_\_\_\_  
Is authorization required at any time? \_\_\_\_\_  
Is a referral required from the family physician? Yes/No