



# Core Wellness

& PHYSICAL THERAPY

## Patient Insurance Worksheet

Core Wellness & Physical Therapy, LLC does not participate in any insurance networks. We will, however, offer guidance on how to manage your out-of-network benefits. We suggest that prior to your first visit you contact your insurance company to confirm your coverage benefits. This form serves as a checklist to help you get all the necessary information in order to maximize your reimbursement.

Patient Name: \_\_\_\_\_

Primary Insurance Company: \_\_\_\_\_

Insurance ID#: \_\_\_\_\_ Group #: \_\_\_\_\_

Plan Type: \_\_\_\_\_ Insurance Tel#: \_\_\_\_\_

Insurance effective date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Name of person you are speaking with: \_\_\_\_\_ ID: \_\_\_\_\_

Time of Day: \_\_\_\_\_ Tracking ID for the call: \_\_\_\_\_

How much is my out-of-network deductible? \$ \_\_\_\_\_

Is there Individual vs. Family deductible? Yes/~~Yes~~/~~No~~ No \$ \_\_\_\_\_

How much of my deductible has been met? \$ \_\_\_\_\_

What is my co-insurance percentage? 10% 20% 30% 40% Other % \_\_\_\_\_

Does my policy require pre-certification (like ORTHONET) for physical therapy services? ~~Yes~~/Yes/~~No~~ No

If yes, Pre-Cert Phone #: \_\_\_\_\_ Pre-Cert Authorization #: \_\_\_\_\_

Number of sessions allowed with this Pre-Cert: \_\_\_\_\_

Expiration Date? Yes/~~Yes~~/~~No~~ No \_\_\_\_/\_\_\_\_/\_\_\_\_

How many out-of network physical therapy visits do I have? \_\_\_\_\_ Visits per yr \_\_\_\_\_

per year/per lifetime \_\_\_\_\_ per condition/per year \_\_\_\_\_

Is there a maximum amount/cap that my plan pays for out-of-network physical therapy? Yes/No \$ \_\_\_\_\_

Number of PT visits used already this year: \_\_\_\_\_

Secondary Insurance: \_\_\_\_\_ Secondary Insurance ID#: \_\_\_\_\_

Secondary Insurance Tel#: \_\_\_\_\_

Effective date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Deductible: \_\_\_\_\_ Co-Insurance payment: \_\_\_\_\_

I understand that I am responsible to obtain accurate information about my insurance policy in order to maximize my benefits. I also understand that I will pay for services at the time they are rendered and it will be my responsibility to seek reimbursement. Core Wellness & Physical Therapy, LLC will provide documentation, such as evaluations and progress notes to assist you in this process.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_