Explanation of Insurance Benefits

Acct #:______________ Date:______________
CORE Provider:_________________________
For office use only

Patient Name: ____ Date of Birth: ____________________

Our records show that your primary insurance policy is with: ____

Effective Dates: ____________________ To ____________________

Authorization Required: ☐Yes ☐No

Auto Accident/Injury: ☐Yes ☐No

For your convenience, we have called to inquire about your physical therapy benefits. The following represents information provided to us by your carrier and should be considered only as a quote. It is possible, that when your claim is submitted for processing, the amounts represented below may be different. We encourage you to contact your insurance carrier directly to confirm all benefits.

Reimbursement for physical therapy services is paid at ________ % of the allowed amount. The remaining ________ % is the patient responsibility. Your deductible is $ ____________ and $ ____________ has been met year-to-date.

Your co-pay for each physical therapy visit is $ ______________

Additional information: ____

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If you have a secondary insurance we will bill one second or supplemental insurance as a courtesy. Please be aware that payment may be denied for services, as we are not contracted with all secondary insurances. If you do not have a secondary or supplemental policy, payment is due after primary insurance has processed your claim. Any amounts not covered by a second or supplemental policy will become the patient's responsibility.

Have you had any type of physical therapy within the last year? ☐Yes ☐No

Have you had any services this year by any Home Health Agency? ☐Yes ☐No

I understand and agree to the above information.

Patient Signature: ____ Date: ____________________

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Last Revision Date: 6.22.2018