Provider **BILLING INFORMATION** page 2

**If this is a Workers' Compensation Claim, please fill out the following information:**

Who is the attending HCP? _____ Phone: _____

Claim number: _____ Date eligibility began: _____

Number of visits authorized: _____ Number of visits remaining: _____

Dates of coverage: _____ Date claim closed: _____

**If this is a Personal Injury Claim, please fill out the following information:**

PIP policy amount: _____ Dates of coverage: _____ PIP available: _____

MedPay amount: _____ Dates of coverage: _____ MedPay available: _____

Liability amount: _____ Dates of coverage: _____ Liability available: _____

Uninsured/Underinsured (UMI) policy amount: _____ UMI available: _____

Has the PIP application been received? ☐ Yes ☐ No

Has an attorney been consulted? ☐ Yes ☐ No Retained? ☐ Yes ☐ No

Name/Firm _____

Address _____ City _____ State _____ Zip _____

Phone _____ Fax _____

**If this is a Private Health Insurance Claim, please fill out the following information:**
(Or, if your Personal Injury claim defaults to secondary coverage, fill this out)

Maximum allowable benefit for Physical Medicine/Rehabilitation: _____

In network: $_____ # visits _____ Remaining $_____ # visits _____

Deductible: $_____ Satisifed to date: $_____ Co-Pay: $_____

Out-of-network: $_____ # visits _____ Remaining $_____ # visits _____

Deductible: $_____ Satisifed to date: $_____ Co-Insurance: $_____

Are these limits just for manual therapy? ☐ Yes ☐ No

If no, what other types of treatment do they include? _____
(i.e., chiropractic, physical therapy, occupational therapy, naturopathy, etc.)

**Assignment of Benefits**

My signature below authorizes and directs payment of medical benefits for services billed to my health care provider: _____

**Release of Medical Records**

My signature below authorizes the release of my medical records including intake forms, chart notes, reports, and billing statements to my attorneys, health care providers, and insurance case managers, for the purpose of processing my claims. (I will inform my practitioner immediately upon signing any exclusive Release of Medical Records with my attorney.)

**Financial Responsibility**

It is my responsibility to pay for all services provided. In the event that my insurance company denies payment or makes a partial payment, I agree to be and remain responsible for the balance. It is also my understanding and agreement that if you have contracted with my insurance company at a discount rate and the agreed-upon fee has been satisfied, the balance owed on those specific visits will be waived.

Signature _____ Date _____

Provider

# BILLING INFORMATION

Patient Name _____ Date _____

Date of Injury _____ ID#/DOB _____

**Billing Policy**

Our office is set up to receive direct payment from insurance companies. For the best chance of reimbursement from your insurance carrier, we ask that you:

- Contact your insurance company to determine your manual therapy coverage and provider stipulations. Coverage depends on your insurance company and the specific plan you have chosen. We have provided a list of questions for you to ask your insurance representative or attorney that will help determine your eligibility for our billing service.
- You will need a current prescription for manual therapy from a primary health care provider, such as a physician or a chiropractor in order to submit your claim. Referrals are current for 90 days unless otherwise specified.

It is important that you understand your insurance policies in order for you to budget for your manual therapy services. You are personally responsible for all charges incurred in our office. We expect payment in full until your insurance coverage has been verified.

We realize that the completion of this form is an added burden to you as a consumer, and we thank you very much for your assistance. This completed form will provide both you and our billing department with important information regarding your manual therapy insurance benefits, and enable us to process your claim in a timely fashion.

**Patient Information**

Is patient's condition related to:

☐ auto collision—In what state? _____
☐ other accident _____
☐ employment ☐ illness

Patient status: ☐ male ☐ female
☐ single ☐ married/partnered ☐ other

Patient relationship to insured
☐ self ☐ spouse/partner ☐ child ☐ other

**Insured's Information** (if other than patient)

Name _____
Address _____
City _____ State ____ Zip _____
Phone: _____
Date of birth _____
Sex: ☐ Male ☐ Female
Employer's Name or School Name _____
_____

**Insurance Information**

Insurance plan name or program name: _____
Member ID#: _____ Group #: _____
Customer service phone #: _____ Date and time you called: _____
Name of customer service representative: _____
Insurance claim address: _____ State: _____ Zip: _____
Does the plan include a Physical Medicine and Rehabilitation benefit? ☐ Yes ☐ No
Who may provide the services? ☐ Massage Therapist ☐ Physical Therapist ☐ Other
Is pre-authorization required? ☐ Yes ☐ No Who can authorize the services? _____
Is a prescription required? ☐ Yes ☐ No Is a referral required? ☐ Yes ☐ No
Who may refer? ☐ MD ☐ DC ☐ ND ☐ PT ☐ Other _____
How often does the referral need to be updated to ensure continuous coverage? _____
Is there a Preferred Provider list for Manual Therapists? ☐ Yes ☐ No
Is _____ on the list? ☐ Yes ☐ No