

INSURANCE VERIFICATION OF BENEFITS
SUGGESTED QUESTIONS TO ASK...

New Freedom Physical Therapy is committed to helping our clients and their families. Your insurance company may reimburse for all or part of physical therapy services, but you will need to find out your specific plan details. Always make a note of the time and date you called your insurance company, the name of the person you spoke with, and the questions asked and answers given!

When you call, be ready to present the following information: 1) the name of the insured; 2) Insured's place of employment; 3) Insurance group number; 4) Insured's ID number (usually his/her social security number); and 5) Name of person requiring therapy, their relationship to the Insured, the referring doctor and their diagnosis.

Preview the questions below and when you call, write in the answers!

1. I'm calling to verify benefits for outpatient physical therapy services for (client's name and relationship to insured). I have a prescription from Dr. _____ with the diagnosis of _____ (see prescription form).
2. I'm seeking physical therapy services from an outpatient practice called New Freedom Physical Therapy. Am I covered if New Freedom is a non-participating provider or an out-of-network provider?
If NO - Can I submit my therapy receipts for reimbursement? _____
If YES - Are there special forms that need to be completed? _____
3. What is my deductible and/or co-pay? _____
4. Will my payments be applied to my deductible? _____
5. Does my policy limit the number of visits per year? NO / YES (write #) _____
6. Does my policy have a cap on the amount of money paid out per year? NO / YES \$ _____
7. What services are covered, or is any specific service excluded? _____
8. CPT codes New Freedom uses are: 97161, 97162, 97163, 97164, 97110, 97530, 97116, 97112 and 97140
Are any of these excluded in the coverage? NO / YES _____
Are there limits of use on any of these codes? NO / YES _____
9. Do I need pre-authorization or pre-certification? NO / YES _____
10. Is Re-certification needed? NO / YES After how many treatments? _____
11. Are there any exclusions to my policy: Is treatment limited to a new illness or injury, does it cover my diagnosis, will it cover therapy if it is not administered in a hospital-affiliated center?

12. What are billing instructions? _____
13. What information do I need to submit? _____
14. Where do I submit it? (complete billing address)

15. Who is the contact person I can call if I have any follow up questions about my case?

NAME

Phone #

Extension#