Health Insurance Benefits Worksheet

We will work with you to determine your health insurance benefits. Depending on the services that we provide, some or all may be reimbursable. Please contact your insurance company to complete this form.

Your insurance company (e.g, CareFirst, Aetna, Cigna, Anthem, etc.):_____

Subscriber (member) ID:_____ Group ID:_____

Member Services Phone (always call this number): _____ Provider Services Phone:

_____

Date you called: _____To whom you spoke:_____

Request verification of eligibility and reimbursement for out of network Occupational Therapy.

Is Occupational Therapy (OT) covered out of network? Yes____No____

Is there a co-payment (fixed or percentage of the charge)? Yes____No____ If "Yes," how much _____

Is there a deductible that must be met before the coverage begins? Yes____No____ If "Yes,"how much: _____
How much has been paid so far: _____

Is there an out-of-pocket maximum after which the insurance company pays everything? Yes____No____ If "Yes,"how much: _____ How much has been paid so far: _____

Is there a limit to number of sessions per year? Yes____No____ If "Yes," how many? ____ and how many of those used so far?_____ Is there a process to request more sessions? Yes____No____ (if yes, describe on back)

Is there a dollar limit to insurance company reimbursement? Yes____No____ If "Yes," how much? _____
and how much, if any, has been paid so far?_____

When is the plan year (e.g., January 1 – December 31)? _____

Is authorization needed before treatment or after the first session? Yes____No____ If "Yes," how is it obtained and from whom?_____

Will the insurance company require information now (to initiate) or in the future (to continue) coverage?
Yes____No____ If "Yes," after how many visits? _____

Information for follow up (contact and telephone) _____

I understand that this worksheet is a recording of my discussion with my insurer and does not create a contract with or obligation of Creative Health Solutions. I remain responsible for all charges and agree to pay them at the time of service unless otherwise arranged.

Patient's Name: _____Parent/Guardian Printed name:_____

Signature: _____Date: _____