BeneFIT Physical Therapy

INTAKE/INS FORM

PATIENT INFORMATION

Patient Name:_____ DOB:_____ Age:_____

Address:_____ Sex: M/F

City:_____ State:_____ ZIP_____

Home Phone:_____ Email:_____

Work Phone:_____

Cell Phone:_____

Referring MD:_____ Diagnosis/Reason:_____

INSURANCE INFORMATION

Insurance:_____ Policy Holder:_____ DOB:_____
Policy #:_____ Group#:_____
Ins Address:_____
City:_____ State:_____ Zip:_____
Ins Phone #:_____

Insurance:_____ Policy Holder:_____ DOB:_____
Policy #:_____ Group#:_____
Ins Address:_____
City:_____ State:_____ Zip:_____
Ins Phone #:_____

INSURANCE VERIFICATION

In-Network

Co-Pay:_____
Deductible:_____
Co-Ins after Deductible is met:_____%
Max # of Visits:_____per_____/unlimited
Referral Required? Yes/No
Pre-Authorization Required? Yes/No
Max dollar amount for OPPT? Yes/No
If so in amount of$_____

Out-of-Network

Co-Pay:_____
Deductible:_____
Co-Ins after Deductible is met:_____%
Max # of Visits:_____per_____/unlimited
Referral Required? Yes/No
Pre-Authorization Required? Yes/No
Max dollar amount for OPPT? Yes/No
If so in amount of$_____