Coverage & Benefits Verification Questionnaire

Information to Have Prior to the Call

Patient: ______________________ Date of Birth: ______________________

Payer: ______________________ Subscriber ID: ______________________

Payer Phone: ______________________ Are you in-network with this payer? Yes / No

Planned Billing Codes: ______________________

Medical Diagnos(es): ______________________

Treatment Diagnos(es): ______________________

Basic Verification Information

Coverage Dates
Effective from: ______________________

Co-Insurance
Annual: ______________________

Copay
Standard: ______________________

Deductible
Annual: ______________________

Additional Verification Information

Yearly Visits to Therapy Allowed: ________ Yearly Visits for Therapy Remaining: ________

Is there a separate count for each service type? Yes / No

Is ST/OT/PT covered? Yes / No

Are the billing code(s) covered when billed with the diagnosis code(s)? Yes / No

Is a referral from the primary care physician required? Yes / No

Is pre-certification required? Yes / No

Is re-certification required? Yes / No

Is an authorization required? Yes / No

Information to Gather at the End of the Call

Representative's Name: ______________________

Reference #: ______________________

Date & Time: ______________________