

PHONE VERIFICATION OF COVERAGE

AUTHORIZATION TO TREAT PATIENT

PATIENT INFORMATION

NAME: _____ Date of Injury / Illness: _____

CLAIM NUMBER: _____ S.S.#: _____

PHYSICIAN: _____ DIAGNOSIS: _____

EMPLOYER: _____

INSURANCE INFORMATION

NAME: _____

PHONE NUMBER: _____ ADJUSTER: _____

SUPERVISOR; CASE MANAGER OR AUTHORIZING PARTY: _____

DATE: _____ TIME OF CALL: _____ Authorization #: _____

Witness'(s): _____

Document every call, date, time and person whom you spoke to and what is said.

PHONE NOTES

(Use back of page if necessary)

INSURANCE COVERAGE:

WORKERS' COMP. <input type="checkbox"/>	P. I. P. <input type="checkbox"/>	M/M <input type="checkbox"/>	OTHER <input type="checkbox"/>	_____
COVERAGE: 100% <input type="checkbox"/> 80% <input type="checkbox"/> 70% <input type="checkbox"/> 60% <input type="checkbox"/> OTHER: _____				
DEDUCTIBLE: \$ _____ HAS IT BEEN MET YET? YES <input type="checkbox"/> NO <input type="checkbox"/> DUE DATE _____				
WHAT, if any, are the restrictions or limitations on the Policy? _____				
Does policy cover CODES: 97124 <input type="checkbox"/> # 97140 <input type="checkbox"/> or other PHYSICAL MEDICINE CODES? Yes <input type="checkbox"/> No <input type="checkbox"/>				
If No, why not? _____				
(If performed & billed by a licensed massage therapist?) Y <input type="checkbox"/> N <input type="checkbox"/> If No, why not? _____				
