INSURANCE STATUS of COVERAGE or AUTHORIZATION

INSURANCE COMPANY: _____

PATIENT:_____ CLAIM # _____

Date Request Received: _____

Date Responded To: _____

WORKERS' COMPENSATION

May I receive authorization to treat patient? Yes _____ NO _____

IF NO, Why not? _____

_____

If any, authorization number or code? _____

Who authorized patient treatment? _____

Date Authorization was given? _____

Time authorization was given: _____

PERSONAL INJURY OR OTHER INSURANCE RELATED CASES

Confirming Benefits for PIP, YES_____ NO_____ For Major Med, YES_____ NO_____

Is There a Deductible? Yes _____ No _____ If Yes, how much? $_____

Has deductible been met yet? YES____ NO_____ If no, amount due? $_____

If Deductible has been met, when is deductible due again? _____

Is a Co-Pay due at time of service? Yes_____ No _____ IF YES, Amount $_____

CORRESPONDENCE

Letter to Carrier: _____ Date: _____

Letter to Patient: _____ Date: _____

Call to Carrier: _____ Date: _____ Time: _____

Spoke to: _____

Comments from Adjuster: _____

_____

Therapist or Caller's Signature: _____ Date:_____