

# STRIDE PHYSIO INSURANCE BENEFIT WORKSHEET

**Use this form when calling your insurance company to ensure that you are asking the correct questions. Feel free to call us if you have any questions or concerns. Please complete by your first visit and we will cross-reference your information with the benefit quote we obtain to ensure that we have been given the correct information.**

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Insurance Plan Name: \_\_\_\_\_

Member ID# (include alpha prefix): \_\_\_\_\_ Group number: \_\_\_\_\_

Customer service phone number (with area code): \_\_\_\_\_

Name of Insurance Customer Service Rep (include date and time): \_\_\_\_\_

Insurance claim address: \_\_\_\_\_

Date eligibility began: \_\_\_\_\_

Deductible: \$ \_\_\_\_\_ Co-pay: \$ \_\_\_\_\_ Co-insurance\*: \$ \_\_\_\_\_

Coinsurance Maximum or Out-of-Pocket Maximum: \_\_\_\_\_

Maximum allowable benefit for physical therapy: \$ \_\_\_\_\_ or # of visits \_\_\_\_\_

Remaining \$ \_\_\_\_\_ or #visits \_\_\_\_\_ for current year as of \_\_\_\_\_

Is my physical therapist a preferred provider for my plan? YES  NO

If your company is an HMO or PPO, and we are NOT a provider for the plan, what is the benefit coverage for Physical Therapy Works? (e.g. 60%, 80% etc.)  
Do you OOPM and Deductibles cross accumulate with my in-network benefit?

Does this plan require a prescription or referral for PT services? YES  NO

Does this plan require pre-authorization for physical therapy? YES  NO

\* Co-insurance is the amount not covered by your insurance policy. The co-insurance is the responsibility of the patient.

**Thank you for your time in completing this worksheet**