Appt. Date & Time :_____
Therapist:_____

3DPT Insurance Verification Form

Insurance:_____ Phone:_____

Patient Name:_____DOB _____ ID # :_____

Patient Phone # : _____Informed of Benefits ____Yes ____No____ Date:_____

Time of call _____ Date of call _____

Person spoke with _____
Outpatient Physical Therapy benefits for New Jersey Office Setting

Effective Date _____

MCR Cap How Much Applied _____

In-network:

Deductible:_____Ind._____Fam.

How Much Met:_____Ind._____Fam.

Max Out of Pocket:_____Ind._____ Fam.

How Much Met:_____Ind. _____Fam.

Co-payment _____

Co-insurance _____

Visit limitations ___yes _____no # Remaining ____

Authorization required _____yes _____no

Referral required _____yes _____no

Script required _____yes _____no

Plan Year _____

Cal Year _____

Co-payment _____

Visit limitations ____yes _____no

Visits Remaining _____

Authorization required _____yes

Referral _____yes _____no

Script_____ yes _____no

_____

_____

Ref#_____

Claims Address:_____

Forms Emailed: _____Yes _____No Date:_____ Initials:_____

_____

THREE DIMENSIONAL PHYSICAL THERAPY