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

Coverage Dates Effective from:	**Co-Insurance** Annual:
Copay Standard:	**Deductible** Annual:

ADDITIONAL VERIFICATION INFORMATION

Yearly Visits for 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:

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