

**1200 OAKLEAF WAY SUITE B 757 LAKELAND DR SUITE A**

 **ALTOONA, WI 54720 CHIPPEWA FALLS, WI 54729**

 **Phone: 715-839-9266 Phone: 715-723-5060**

 **Fax: 715-839-8761 Fax: 715-723-5149**

 **9 MAIN ST**

 **BLACK RIVER FALLS, WI 54615**

 **Phone: 715-670-0310**

 **Fax: 715-670-0315**

**PATIENT INSURANCE VERIFICATION**

PATIENT’S NAME \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PLEASE TAKE THIS FORM HOME AND COMPLETE**

**FOR YOUR OWN PROTECTION/KNOWLEDGE AND DUE TO INCONSISTENT INFORMATION GIVEN TO NWT, WE ARE ASKING THAT YOU CONTACT YOUR INSURANCE COMPANY TO VERIFY YOUR BENEFITS. THANK YOU.**

**IF YOU HAVE THE FOLLOWING INSURANCES, PLEASE DISREGARD QUESTION #1: GROUP HEALTH, PRAIRIE STATES, PREVEA, SECURITY HEALTH PLAN, WEA, WPS**

1) IS PRE-AUTHORIZATION REQUIRED? Y / N IF YES, PHONE/FAX # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **IF YES, PLEASE CALL NWT ASAP WITH THIS INFORMATION SO WE CAN START THE PROCESS IMMEDIATELY.**

2) VISIT LIMIT FOR OUTPATIENT PHYSICAL THERAPY? Y / N # OF VISITS? \_\_\_\_\_\_\_\_\_\_

3) HAVE YOU BEEN SEEN IN PHYSICAL THERAPY IN ANOTHER FACILITY DURING THIS CALENDAR YEAR? Y / N IF YES, # OF VISITS? \_\_\_\_\_\_\_\_\_

4) VISIT CO-PAY? Y / N IF YES, $ AMOUNT \_\_\_\_\_\_\_\_\_\_ (**CO-PAY IS DUE AT TIME OF SERVICE**)

5) DOES YOUR INSURANCE REQUIRE AN MD ORDER/OR REFERRAL FOR PHYSICAL THERAPY?

 Y / N

6) **IF YOU ARE RECEIVING A BRACE OR SPLINT** PLEASE GET BILLING CODE FROM OUR FRONT DESK AND CALL YOUR INSURANCE TO VERIFY COVERAGE AND IF WE NEED TO

 PREAUTHORIZE BEFORE DISPENSING. PHONE # TO PREAUTH \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**\*\*\*\*IF YOU ARE PLANNING ON ATTENDING POOL THERAPY, PLEASE VERIFY THAT YOU HAVE POOL COVERAGE WITH THE CODE 97113.**

\*\*\*\***IF YOU HAVE AETNA INSURANCE\*\*\*\*\*WHEN VERIFYING YOUR BENEFITS, PLEASE PROVIDE CUSTOMER SERVICE WITH THE NAME OF YOUR THERAPIST, NOT THE NAME OF OUR FACILITY. THEY WILL NOT RECOGNIZE THE NAME NORTHWOODS THERAPY AS AN IN NETWORK PROVIDER.**

**THANK YOU FOR YOUR TIME.**

**PLEASE RETURN THIS AT YOUR NEXT SCHEDULED APPOINTMENT.**