Therapy Insurance Verification

Resident: _____ Date: _____

Therapy PT _____ OT _____ ST _____

☐ Orders in Chart

☐Medicare Primary Medicare #: _____ effective date _____

Cap used: OT: _____ PT/ST: _____

☐ Insurance Primary: ☐Medicare replacement plan ☐ Commercial plan

☐ Insurance Supplemental

Insurance Name: _____

Plan #: _____ effective date _____

Precert: ☐ No ☐ Yes Auth #: _____

Deductible / copay information: _____

Benefit Guidelines/Authorization Process:

_____

_____

☐ Medicaid Primary Medicaid #: _____ effective date _____

Precert: ☐ No ☐ Yes Auth #: _____

Benefit Guidelines/Authorization Process:

_____

_____