TRI-FIT PHYSICAL THERAPY
PRIVATE INSURANCE Verification/Authorization

New PT:_______Returning PT:_______

Date of Patient Call______/______/______ Date of Initial Appointment______/______/_____ Time:____________

PERSONAL INFORMATION:

Last Name____ MI_____ First Name________________________________

Date of Birth _____________ Sex ____ Marital Status: S M D W Email:__________________________________

Address___________________________________City________________________ State_______ Zip ______________

Home #:_____________________________ Work #:__________________________ Cell #:_________________________

EMPLOYMENT: Full-Time Part-Time Retired Disabled Unemployed

Employer:____ Occupation _________________________________

Employer Address____________________________________ City___________________ State ______ Zip__________

INSURANCE:

Primary Insurance________________________________ ID #____________________________ Group #____________

Policy Holder Name ____ Relation to Patient____________________

Policy Holder SS#___________________________________ Policy Holder Date of Birth____________________

Billing Address____ Phone #_______________________

Secondary Insurance______________________________ ID #____________________________ Group #____________

Policy Holder Name ____ Relation to Patient____________________

Policy Holder SS#___________________________________ Policy Holder Date of Birth___________________

Billing Address____ Phone #_______________________

REFERRAL:

Referring Physician____ Phone #__________________________________

Primary Physician ____ Phone #__________________________________

Diagnosis / Type of Injury______________________________________ Date of Prescription:_________________________

Has patient received Physical Therapy in the Past Calendar Year? YES / NO If YES please provide last date:___________

*** ***For Office Use Only***

MEDICARE CAP Amount Used: $__________________ Date of last MEDICARE VISIT: _________________

Date of Insurance Call _____/_____/_____ Spoke With____________________ Call Ref #_______________________

Pre-Cert/Auth Required: YES / NO Insurance Effective Date:___________

Authorization #_________________________________ Authorized Visits #: ____________ Expires_____/_____/_____

Co-Pay $___________per visit Co-Ins: %___________ Deductible: $____________ Amt Ded Met: $_______

OTHER:____

____

____

____

____