DATE: _____

INSURANCE VERIFICATION for PHYSICAL THERAPY BENEFITS

Bellingham Physical Therapy, LLC
TIN #91-1705634 NPI #1023016102
360-647-0444
Physical Therapist _____
Diagnosis _____

Subscriber Name _____ DOB_____ ID#_____

Patient Name _____ DOB _____ gr#_____

Insurance Co. _____ Phone# _____

Ins.Contact:_____

Physical Therapy Benefits Yes No

Combined benefits PT / OT / ST Yes No
(massage / cardiac rehab / respiratory)

Pre-existing Condition Limits: _____

Limits: # of Visits _____ and/or Dollar Amount _____

Benefits used this year: # of Visits _____ Dollar Amount _____

Deductible: Amount: _____ Met thus far this year_____

What percentage of the allowable charge is paid by insurance? _____

What percentage is patient responsibility? _____

Is there a co-pay? Yes No $ Amount _____

Does patient need: Prior Authorization / Referral / Written Order / Prescription