Tri-Motion Rehab
Your Life in Motion
www.tri-motionrehab.com

Insurance Worksheet

This is to help you understand your insurance plan and benefit coverage for physical therapy services. Please see your original contract for full benefit explanation. You are ultimately responsible for all costs of service.

Insurance Plan Name _____

ID # _____ Group/Policy # _____

Name of Insured (if not self) _____ Insured's DOB: _____

Signature of Insured _____ Date _____

Relationship to Insured _____ Insured's Employer: _____

Is there another Health Benefit Plan? Y N

If yes: Secondary Insurance Plan Name
Who carries the secondary plan
This person's date of birth
Policy or group #
Employer

Call your insurance company with the following questions:

- Does my plan cover outpatient out-of-network physical therapy? Y N
- Do I need a physician referral for physical therapy services? Y N
  If Yes, Is a referral from a chiropractor ok? Y N
- What percentage will insurance cover out-of-network? _____ %
- What is my co-pay or co-insurance? $ _____
- What is my out-of-network deductible? $ _____
- How much have I met? $ _____
- How many sessions are allowed per year? # _____
- How many units per session are allowed? # _____
- To what address should my claims be sent to?
- Is there any other information I should be aware of?

Please bring this completed worksheet back to the clinic for preparation of your insurance claim form

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