## **Physical Therapy Reimbursement Form**

| Patient Name            |  |
|-------------------------|--|
|                         |  |
| Date of Birth           |  |
|                         |  |
| Phone Number            |  |
|                         |  |
| Email                   |  |
| Email                   |  |
|                         |  |
| Address                 |  |
|                         |  |
| Insurance Provider      |  |
|                         |  |
| Policy Number           |  |
|                         |  |
| Physical Therapist Name |  |
| Thysical merapist value |  |
|                         |  |
| Therapist NPI           |  |
|                         |  |
| Clinic Name             |  |
|                         |  |
| Clinic Phone            |  |
|                         |  |
| Date of Service         |  |
|                         |  |
| CPT Code                |  |
| CFI Code                |  |
|                         |  |
| Amount Paid             |  |
|                         |  |
| Diagnosis               |  |
|                         |  |
| ICD-10 Code             |  |
|                         |  |
| Additional Notes        |  |
|                         |  |
|                         |  |
|                         |  |
|                         |  |