Physical Therapy Insurance Verification Form

Patient Information

Full Name

Date of Birth

Phone Number

Address

City

State

Zip Code

Insurance Information

Primary Insurance Company

Policy Number

Group Number

Insurance Phone

Subscriber Name

Subscriber DOB

Relationship to Patient

Verification Details

Effective Dates

Deductible (Individual/Family)

Co-pay / Co-insurance

PT Visits Allowed per Year

Visits Used

Pre-Authorization Required

Notes

Verified By

Verified By (Name)

Date