

PREMIER

PHYSICAL • THERAPY

PATIENT INFORMATION

First Name: _____ **Last Name:** _____ **MI:** _____ **M F**
SS#: _____ - _____ - _____ **D.O.B:** ____/____/____ **Marital Status:** _____
Address: _____ **City:** _____ **State:** _____ **Zip:** _____
Home Phone #: _____ **Cell Phone #:** _____
Employer: _____ **Occupation:** _____ **Phone:** _____
Emergency Contact: _____ **Relation:** _____ **Phone:** _____

Script Received _____ **Patient to bring script** _____ **Script to be faxed** _____
Script Date: _____ **Diagnosis:** _____ **Referring MD:** _____
Referring MD UPIN: _____ **NPI:** _____
Claim Type: General Medical Condition _____ W/C _____

Policy Holder Name: _____ **DOB** ____/____/____ **SS#** _____
Primary Insurance: _____ **Phone:** _____
Address: _____ **City:** _____ **State:** _____ **Zip:** _____
Policy/ID #: _____ **Group #** _____

Is pre-cert, pre-auth required? YES NO Auth #: _____

Effective Date: ____/____/____ Auth dates through: _____

Deductible: Y N Amount \$ _____ Met for year: Y N met to date \$ _____

Out of Pocket: Y N Amount \$ _____ Met for year: Y N OOP to date \$ _____

Claims pd @ _____%. Pt pays _____% coins. OOP met claims paid @ _____

Copay per visit: Y N Amount \$ _____ Max \$ or visits _____ remaining _____

Limitations: _____ Is aquatic therapy (97113) covered Y N

Info furnished by: _____ Reference #: _____ Date: _____ Time: _____

Secondary Insurance: _____ **Phone:** _____
Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Policy/ID #: _____ **Group #** _____

Effective Date: ____/____/____ Coverage of Primary Insurance: Deductible Y N Co-Ins. Y N

Notes: _____

Information furnished by: _____ Reference #: _____ Date: _____ Time: _____

Worker's Comp: _____

Billing Address: _____

Claim # _____

Adjustor: _____ Phone #: _____ - _____ - _____ Fax #: _____ - _____ - _____

Case Manager: _____ Phone #: _____ - _____ - _____ Fax #: _____ - _____ - _____