RESULTS PT

Results PT does NOT participate with your insurance plan. Health insurance is an agreement between you and the insurance company. Payment is made in cash or credit card to the provider directly on the date of service. Paid invoice will be provided to you.

Medical Billing Services will submit your insurance claim for you and debit your credit card to provide this service. Your insurance company will receive the claim and send your reimbursement check to YOU directly by mail. Non-payment, incorrect reimbursement, etc. is your responsibility with your insurance company. Some insurance carriers cover all charges or only a portion of the charges billed for your service. The following information is required to submit your insurance claim.

PATIENT INFORMATION

First Name_____ Last Name_____ MI_____

Address: _____ Apt # _____

City: _____ State: _____ Zip: _____

Cell Phone: _____ Work Phone: _____ Evening: _____

Patient Email Address: _____

Date of Birth: _____ SS# _____ Sex: M ___ F ____

Marital Status: Married ____ Single ____ Divorced ____ Widowed ____ Spouse's Name: _____

Is your condition related to a specific trauma or injury? YES _____ NO _____ / Date of Injury _____
Injury location: Work ____ Auto Accident _____ Other _____
Is there an attorney involved? YES ____ NO ____ Name & Phone _____

WORK INFORMATION

Employer's Name: _____

Employer's Address: _____

City: _____ State: _____ Zip: _____

Work Phone Number: _____ Ext. _____ Occupation _____

WORKER'S COMPENSATION INSURANCE / AUTO INSURANCE INFORMATION

Worker's Compensation Carrier / Auto Insurance: _____

Address: _____ State: _____ Zip: _____

Insurance Adjuster: _____ Claim Number: _____

Insurance Adjuster's Phone Number: _____

MEDICARE & PRIVATE INSURANCE INFORMATION

FAMILY PHYSICIAN / ORTHOPEDIC SURGEON

Name; _____ Address _____ Phone_____

PRIMARY INSURANCE

Patient Name: _____ Is this your coverage? YES ____ NO ____

Insured Person Name: _____ Relation to Patient: _____

Insured Date of Birth: _____ Policy # _____ Group # _____

Insurance Company Name: _____

Insurance Phone Number: _____ Contact Name: _____

SECONDARY INSURANCE

Patient Name: _____ Is this your coverage? YES ____ NO ____

Insured Person Name: _____ Relation to Patient: _____

Insured Date of Birth: _____ Policy # _____ Group # _____

Insurance Company Name: _____

Insurance Phone Number: _____ Contact Name: _____

Authorization to Release Information for Treatment and Medical Billing

I hereby authorize Results PT and associated medical billing agency to release information from the patient's financial or medical records to any third party payer, employer, or insurance company (including but not limited to Medicare, Blue Cross/Blue Shield, commercial health insurers, and health maintenance organizations) which are responsible in whole or part for payment of these physical therapy charges. I also authorize RESULTS PT to obtain any testing, physician evaluations or radiological imaging reports that are pertinent to the condition for which I am being treated.

Patient Signature: _____ Date: _____
Print Name: _____
Guardian / Parent: _____ Date: _____

PATIENT IDENTIFICATION
INSURANCE VALIDATION

COPY FRONT AND BACK OF DRIVER'S LICENSE & INSURANCE CARDS

Driver's License

Front

Driver's License

Back

Primary

Insurance Card

Front

Primary

Insurance Card

Back

Secondary

Insurance Card

Front

Secondary

Insurance Card

Back

MEDICAL BILLING & CONSULTING

5623 East Dunbar Road
Monroe, Michigan 48161
Phone 734-241-3891 / Fax 734-241-0014