Provider/Clinic Susan Cohn and Associates

Insurance Coverage / Benefit Verification

Insurance Information	
Insurance Carrier :	Claims Dept Phone #:
Insurance ID # :	Group #:
Member / Patient Information	
Subscriber Name :	Subscriber Birth Date :
Patient Name :	Patient Birth Date :

Diagnosis Code (s)	Procedure Code (s)	(B)illable / (N)on-Billable

Date of Call:		Call Made By:	
Insurance Representative's Name:			
Coverage Effective Date:		**Rehab Therapy covers services considered medically necessary to restore function lost due to **injury, illness or congenital** anomaly**	

Is there Rehab Therapy Benefits? **	Yes ☐ No ☐	Yearly Benefit Limit	
☐ Co-payment?	If yes - amount $	Required Documentation	
☐ Co-insurance?	If yes - percentage %	☐ Prescription?	☐ Chart Notes?
☐ Deductible?	Remaining amount $	☐ Evaluation?	☐ Prior Authorization?

Is there Neuro-Developmental Benefits?	Yes ☐ No ☐	Yearly Benefit Limit	
☐ Co-payment?	If yes - amount $	Required Documentation	
☐ Co-insurance?	If yes - percentage%	☐ Prescription?	☐ Chart Notes?
☐ Deductible?	Remaining amount $	☐ Evaluation?	☐ Prior Authorization?

If prior authorization or pre-cert required ~		Are there any provider types excluded from coverage?	
Pre-cert /prior auth fax number:			

Additional Coverage / Limits / Exclusions and Requirements – **i.e. ltr of medical necessity; pre-determination**