**INITIAL INTAKE / INSURANCE VERIFICATION (**INTERNAL USE ONLY**)**

**(Bolded Information to be completed at time of patient's initial call)** **OFFICE: _____**

**Appointment: Date: _____ Time: _____ am / pm Diagnosis (Body Part): _____**

**Patient: _____DOB: _____ Gender: M F Injury Date: ___/_____/_____**

**Address: _____**

**City: _____ State: _____ Zip Code: _____**

**Cell Phone: _____ Email: _____**

**Home Phone: _____ Referring Physician: _____**

**Employer: _____ DOI (WC / Auto): _____ Claim Number: _____**

**Primary Insurance Carrier**: _____

**Member ID:_____Group:_____**

**Guarantor (If Applicable): _____ DOB: _____ Relationship: _____**

Spoke with: _____ / Automated / Adjuster *Reference # for Call: _____

Benefit Policy / Contract Year: _____/_____/____ TO _____/____/____

Deductible: $ _____ Amount met: $ _____ Balance remaining: $ _____

Out of pocket: $ _____ Amount met: $ _____ Balance remaining: $ _____

Percentage of coverage: _____% Patient co-payment: $_____

Visit Limit: _____ Amount Used: _____ Is a referral or predetermination required? _____Yes ___No

Is Authorization Required? ___Yes ___No

Authorization phone number: _____ Extension: _____

Authorization number: _____ Authorization recorded by:_____

**Secondary Insurance (if applicable): _____**

**Member ID:_____Group:_____**

**Guarantor: _____ DOB: _____ Relationship_____**

Spoke with: _____ / Automated / Adjuster *Reference # for Call: _____

Effective date of coverage: _____ ____Active Benefit / Contract Year: ___/___/__ TO _____/____/____

Deductible: $ _____ Amount met: $ _____ Balance remaining: $ _____

Out of pocket: $ _____ Amount met: $ _____ Balance remaining: $ _____

Percentage of coverage: _____% Patient co-payment: $_____

Visit Limit: _____ Amount Used: _____

Additional Notes / Comments: _____

_____

Verified by: _____Date: _____Time: _____