Questions to Ask Your Insurance Carrier Before You Verify Your Appointment

Your Primary Insurance is:_____ Secondary:_____
Member #:_____ ID#:_____
Member Services Phone #:_____
Date you Called: _____ Whom You Spoke To: _____

1. Verify what the coverage would be for the service your child needs (occupational therapy)_____
   _____
2. Any exclusions?_____
3. Is there habilitative benefits? _____
4. Do I have a co-payment or is there a percentage of the bill I will be responsible for?_____
   _____
5. Does my plan require a deductible to be paid for the calendar year before the coverage begins?_____ What is the dollar amount?_____
6. Does my child have an out of pocket maximum that I pay per calendar year?_____
   _____
7. Does my insurance plan cover only a limited number of sessions for each calendar year?_____
8. Is there a requirement that I get prior authorization and/or a referral before I see a clinician? Yes_____ No_____ If yes, who do I contact?_____ Phone#: ____
   _____

   I have verified the information above and understand that I am responsible for any charges that the insurance does not cover. **Please sign this form and return with a copy of your insurance card and completed paperwork.** Failure to complete and return this form may result in a delay in scheduling an appointment. Thank you for your cooperation.

   Patient Name: _____ Date: _____

   Parent/Guardian Signature: _____