ACTIVE PLUS PHYSICAL THERAPY

Insurance & Billing Information

Please bring your insurance card(s) and photo ID.

PRIMARY INSURANCE

INSURANCE COMPANY

PLAN NAME / TYPE

MEMBER ID

GROUP NUMBER

POLICY HOLDER NAME

POLICY HOLDER DATE OF BIRTH

RELATIONSHIP TO PATIENT

INSURANCE PHONE (BACK OF CARD)

SECONDARY INSURANCE (IF ANY)

INSURANCE COMPANY

MEMBER ID

GROUP NUMBER

POLICY HOLDER NAME

WORKERS' COMPENSATION CLAIM (IF APPLICABLE)

EMPLOYER

DATE OF INJURY

CLAIM NUMBER

CARRIER (E.G. CORVEL, SEDGWICK)

ADJUSTER / CASE MANAGER NAME

ADJUSTER PHONE & EMAIL

AUTO / NO-FAULT CLAIM (IF APPLICABLE)

AUTO INSURANCE COMPANY

DATE OF ACCIDENT

CLAIM NUMBER

ADJUSTER NAME & PHONE

SELF-PAY

☐ I will pay directly (self-pay / cash-based therapy)

ASSIGNMENT OF BENEFITS & FINANCIAL RESPONSIBILITY

I authorize payment of insurance benefits directly to Active Plus Physical Therapy, PC for services provided, and I authorize the release of information necessary to process my claims.

I understand that coverage varies by plan and that I am responsible for any co-payments, co-insurance, deductibles and charges not covered by my insurance. Active Plus will verify my benefits as a courtesy, but verification is not a guarantee of payment.

PATIENT (OR GUARDIAN) SIGNATURE

DATE