CORPSTRENGTH PHYSICAL THERAPY, LLC

Patient Insurance Information Form

Client Name_____Date of Birth_____ Primary Phone_____H/W/C

Parent Name (if minor)_____ Email_____

Street Address: _____City: _____State:_____Zip:_____

Primary Physician:_____ Referred by: _____ Diagnosis: _____

Primary Insurance Co: _____ Phone #_____

Policy Holder (if other than patient) _____ DOB_____ Relationship: _____

ID# _____Group #_____

Do you have a health savings or flex spending account (FSA)?_____yes - as this can be used for copay etc.

Secondary Insurance Co._____Phone #_____

Policy Holder (if other than patient) _____ DOB_____ Relationship: _____

ID# _____Group #_____

----------Office Use Only Below----------

Primary Claims Mailing Address:_____

Deductible: $_____ (Met $_____) Cal Yr/Cont Yr. Out of Pocket Max: $_____ (Met $_____)

Visit Limit: _____ per yr. PT/OT/Chiro/ST. Used _____ visits. HSA/HRA? _____

Copay: $_____ Covered by ins. _____% Effect date: _____ Call Notes: _____

RX/referral/precert/LMN/pre-exist/other: _____

UHC Group Check: 888-329-5182 Notification required: Yes_____ No_____

Secondary Claims Mailing Address:_____

Deductible: $_____ (Met $_____) Cal Yr/Cont Yr. Out of Pocket Max: $_____ (Met $_____)

Visit Limit: _____ per yr. PT/OT/Chiro/ST. Used _____ visits. HSA/HRA? _____

Copay: $_____ Covered by ins. _____% Call Notes: _____

RX/referral/precert/LMN/pre-exist/other: _____