PediaSpeech Services, Inc

Insurance Benefits and Eligibility

We are pleased to provide your child with quality speech/language and occupational therapy services. We are committed to maintain the highest standards possible for your child's optimum progress. We appreciate your business and look forward to working with you and your child!

As you are aware, as a courtesy, our office submits insurance claims for those clients who have provided their insurance information. However, your insurance company and your personal policy may not allow for coverage of services provided at our office. Please provide us with the information you have received after contacting your insurance company regarding coverage for speech therapy and/or occupational therapy:

Please give your insurance company this information regarding your child:

Diagnosis Code(s): _____

CPT Code(s): _____

1. Client Name: _____ Date of Birth: _____
2. Name of Primary Insurance Company: _____ ID Number: _____
3. Phone Number for Insurance Company: _____
   (usually found on back of card)
4. Name of Insurance Company Representative to whom you spoke and ID number:
   _____
5. My insurance company stated that my policy is active as of _____ and that my dates of coverage are from _____ to _____.
6. My insurance company stated that my individual deductible for 2015 is $_____.
   I have met $ _____ of the individual deductible as of _____.
7. My individual out-of-pocket expense for 2015 is $_____.
   I have met $_____ of the individual out-of-pocket as of _____.

8. My family deductible for 2015 is $_____.

I have met $_____ of my family deductible as of _____.

9. My family out-of-pocket expense for 2015 is $_____.

I have met $_____ of my family out-of-pocket as of _____.

10. My deductible ☐ DOES ☐ DOES NOT apply to therapy visits.

11. My insurance company has stated that my policy allows _____ (number of) visits in a: ☐ calendar year period **OR** from _____ to _____(dates)

12. My visits are shared with other therapies: ☐ Yes ☐ No If shared, with whom?

SLP OT PT Other: _____

13. I have used _____ (number of) visits as of _____.

14. My insurance company stated that my copay will be $_____ per session (due each session)

15. Is a Physician's referral required: ☐ Yes ☐No

Diagnosis Code: _____

16. Is a PreAuthorization/PreCertification required: ☐ Yes ☐ No If yes, provide phone number, fax number and contact person's name to acquire authorization: _____

_____

_____

17. My insurance company stated that speech therapy: ☐ MAY be covered ☐ will NOT be covered

Please list description of what will not be covered: _____

_____

18. My insurance company stated that clinical notes: ☐ ARE required for payment ☐ are NOT required for payment. If required please list the fax number for where to send: _____

19. My insurance company stated that occupational therapy: ☐ MAY be covered ☐ will NOT be covered. Please list description of what will not be covered: _____

_____

20. My insurance company stated that clinical notes: ☐ ARE required for payment ☐ are NOT required for payment. If required please list the fax number for where to send: _____

21. I have a secondary insurance company: ☐ Yes ☐ No If yes, what is the name of your secondary insurance company and ID number? _____

_____

This information is accurate as of _____. I am responsible for staying up-to-date regarding my insurance coverage. The above information is subject to change at any time. I must inform you immediately should my insurance coverage and benefits change. PediaSpeech is not responsible for keeping up with any changes made by me, my employer or my insurance carrier. I will provide a copy of my insurance card(s) to PediaSpeech for verification.

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Note from the PediaSpeech Services, Inc.:

Please remember that many insurance companies cover speech therapy and/or occupational therapy only based on "medical necessity." Most insurance companies deny therapy for developmental delay. Although you, and we, can call and confirm coverage, we have experienced a significant amount of ambiguity with the information from insurance companies. **Confirmed coverage from your insurance, either verbal or in writing, in no way guarantees their payment. The only guarantee we have of coverage is their response to our direct bill.** Although we will bill insurance for every claim, you are responsible for any bills unpaid by your insurance company. We bill immediately after services but it can take 30-60 days for the insurance company to determine their payment. **We will gladly file insurance with all our in-network carriers, but you may be responsible for meeting your**

deductible, co-pay or payment in full. You are ultimately responsible for knowing your insurance benefits and coverage and for meeting your deductible.

_____	_____
Patient Name	**Date of Birth**
_____	_____
Signature of Guarantor	**Date**