Insurance Benefits Check Form

This is the basic information you will need when you call your insurance company. If you have multiple children, please complete this form and verify benefits for each child. Some insurance companies have different rules depending upon the age of the child.

Child's Name:	Child's DOB:
Insurance Company:	Insured ID#
Group#	Policy Holder's Name:
Policy Holder's DOB:	Effective Date for Coverage:

Questions to Ask:

Is The Therapy SP/OT, LLC an in-network provider?	Yes No
Are occupational therapy and speech therapy services covered under this plan?	Yes No
Are habilitative services covered for occupational therapy and speech therapy?	Yes No
Is there a limit to the number of visits per year?	Yes No If yes, how many visits for each service?
Do I have a co-payment or co-insurance that I'm responsible for?	Yes No If yes, what is it?
What is my deductible?	
What is required for medical necessity?	
Are there any inclusions or restrictions? Yes No	ST: articulation, phonology, fluency, voice, language, swallowing OT: sensory, feeding, ADLs
Is prior authorization required for services?	Yes No If yes, where should it be sent?
Name of the representative you spoke with:	
Date of call:	Call reference number: