NW Sports Physical Therapy, Inc.
NW Hand Therapy

PRIMARY INSURANCE BENEFIT INFORMATION

NOTE: THIS IS A QUOTE OF BENEFITS AND NOT A GUARANTEE OF PAYMENT

As a courtesy to you we will call and receive a quote of benefits as well. This information will help you verify your PHYSICAL THERAPY benefit.
****Please bring this form in with you to your initial appointment after calling your insurance company.****

Policy effective date:	Max benefit:	Benefit remaining:
Visit limit:	Deductible:	Deductible remaining:
Copay amount:	Percentage of coverage:	Out of Pocket Max/Met: /

Doctors Prescription required? ❑ Yes ❑ No (Self Refer)
If yes, from ❑ Primary Care Provider or ❑ Specialist

Authorization required? ❑ Yes ❑ No If yes, authorization # _____
Number of visits authorized _____
Expiration date of authorized visits _____

Physical Therapist rendering therapy in network or out of Network? ❑ In network ❑ Out of network

Insurance representative that gave insurance quote:	Date of quote: / /