POST EVALUATION INSURANCE COVERAGE FORM

Thank you for choosing Family Achievement Center for your/your child's therapy needs. Therapy services are being recommended for you/your child. **The additional information provided below will further assist you in determining your insurance coverage. We recommend you contact your insurance company once again and provide them with the codes below so you are fully informed of your benefit coverage prior to the start of therapy**.

We at Family Achievement Center are available to answer any insurance questions you may have, however, we do not guarantee coverage or payment by your insurance company.

We look forward to working with you/your child.

Thank you,
The Staff of Family Achievement Center

To Be Completed by Therapist

PT OT ST Services were recommended.

Diagnosis Codes (ICD-10 Codes): _____

Procedure Codes (CPT Codes): _____
(Not necessarily limited to the above codes)

Note: When calling your insurance provider, you will need to specify you are seeking Habilitative Therapy services (examples include but are not limited to: developmental delay, language delay, gross motor delay, sensory processing issues) ie: NOT due to injury or illness.

2101 Wooddale Drive, Suite A ● Woodbury, MN 55125
Phone: (651) 738-9888 ● Fax: (651) 738-9889 ● www.familyachievement.com

FAMILY ACHIEVEMENT CENTER

INSURANCE INFORMATION – PLEASE COMPLETE

If you have medical insurance and would like to receive the maximum benefits available to you from your insurance company, it is important that **you** contact your insurance company **prior to your first visit**. We are available to answer any insurance questions you may have, however, Family Achievement Center can only assist you and cannot guarantee payment from your insurance company. **Please bring this completed form to the evaluation appointment**.

Please contact your insurance company for the following information:

Does my policy cover ***habilitative / ****rehabilitative therapy services for the following disciplines? (Select one – see definitions below)

Occupational Therapy Yes or No
Physical Therapy Yes or No
Speech Therapy Yes or No

* ex: developmental delay, language delay, gross motor delay (not due to injury or illness)
* * due to injury or illness/restoring function

Do I need prior authorization **or** an insurance referral for:?

Speech Therapy Yes or No
Occupational Therapy Yes or No
Physical Therapy Yes or No

Occupational Therapy: Does my policy cover sensory integration therapy? Yes or No

Speech Therapy: Does my policy cover stammering or stuttering? Yes or No

Are there visit limitations for therapy services? Yes or No Number of visits allowed_____

Do I have a deductible? Yes or No Amount $_____

How much of the deductible has been met? Amount $_____

Do I have co-insurance for each visit? Yes or No Amount $_____

Percentage of co-insurance Amount _____%

Do I have an office copayment for each visit? Yes or No Amount $_____

I have read and I understand my financial responsibility as stated above. I authorize direct payment of benefits from my insurance company to Family Achievement Center, Inc.

Responsible Party Name

Patient Name

Responsible Party Signature

Date

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