ADI REHAB

557 S. FAIRFAX AVE, LOS ANGELES, CA 90036 PHONE (323) 933-9060 FAX (323) 933-9807

10585 SANTA MONICA BLVD, #100, LOS ANGELES, CA 90024 PHONE (310) 481-0644 FAX (310)474-4033

[ ] MEDICARE

INSURANCE VERIFICATION

[} PRIVATE

Patient's Name:______________________________ Called Date:____________________

Date of Birth:______________________________ Gender: ____________________

Insurer's Name:______________________________ Relation to patient:____________________

Insurer's Date of Birth: ______________________________

Insurance Name:______________________________ Phone #:____________________

Group #:____________________ ID #:____________________

Medicare #______________________________ [ ] A [ ] B [ ] other

Insurance/ Benefit Verification

HMO [ ] PPO [ ] POS [ ] EPO [ ]

Insurance Effective Date: ______________________________

Does this plan require pre-certification? Yes No

Is a prescription required? Yes No

% covered by insurance?______________________________

Co-pay amount if any?______________ Co-Insurance?______________

Out of Pocket?______________ Life time?______________

Deductible? Yes No Deductible amount: ______________

Has it been Met? Yes No

As of (date):______________ How much?______________

Are there any Limitations? Yes No

What are they? ______________________________

____

Where do I mail the claims?

____

____

____

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Spoke with:______________________________

For Medicare Call: **(866) 931-3903**

Effective Date: ______________________________

Deductible? [ ]Yes [ ] No **(Deductible amount: $155.00)**

Has it been Met? [ ] Yes [ ] No

As of (date):______________ How much?______________

Is Medicare primary? [ ] Yes [ ] No

Is patient using Part-B? [ ] Yes [ ] No [ ] Both

Does this member have HMO involvement? [ ] Yes [ ] NO

Does member have current Home Health involvement? [ ]Yes [ ] No

Spoke with:______________________________

NOTES:______________________________

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H/H Verification Date______________ Spoke with______________

Is P.T. a covered benefit if the patient has not been hospitalized &/or had surgery? ______

Please Circle One: IN NETWORK / OUT OF NETWORK

Please initial here once you've been informed of your benefits: ______________________________

____

Verified by