Pediatric Therapy Network
Leading the way in helping children

Insurance Information

Patient:

(Legal Name)Last _____ First _____ MI_____ D.O.B_____

Primary Insurance Information: (please bring all insurance cards at time of visit)

Insured's Name (who has policy)_____ Insured's D.O.B_____

Insurance Company Name_____ Insurance ph # (on back of card)_____

Provider ID#_____ Group # _____

Office use:

DEDUCTIBLE AMT._____ AMT. MET _____ TYPE POLICY _____ COPAY AMT. _____

MAX VISITS _____ VISITS MET _____ POLICY PERIOD _____

EXCLUSIONS/LIMITATIONS_____

AUTH. REQUIRED_____ INS. REP NAME_____

DIRECT EXT. # _____ DATE/TIME OF CALL _____ CONFIRM #_____

Secondary Insurance Information: (please bring all insurance cards at time of visit)

Insured's Name (who has policy)_____ Insured's D.O.B_____

Insurance Company Name_____ Insurance ph # (on back of card)_____

Provider ID#_____ Group # _____

Office use:

DEDUCTIBLE AMT._____ AMT. MET _____ TYPE POLICY _____ COPAY AMT. _____

MAX VISITS _____ VISITS MET _____ POLICY PERIOD _____

EXCLUSIONS/LIMITATIONS_____

AUTH. REQUIRED_____ INS. REP NAME_____

DIRECT EXT. # _____ DATE/TIME OF CALL _____ CONFIRM #_____

I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO: Pediatric Therapy Network, LLC.

_____ _____ _____

Parent/Guardian Printed Name Signature Date