INSURANCE VERIFICATION
PROVIDER: Colleen M. Liaga, PT

Primary_______ Secondary_____
IN-NETWORK:___________________________
MD:___________________________
RX DATE_______________________________
DX:___________________________

PATIENT:________________________________ID#:_______________________
POLICY HOLDER:____________________________
HOLDER SS#:______________________
GROUP#:___________________________________
DATE OF BIRTH______________________
INS. CO.:__________________________________
PHONE #:_____________________________
INS. ADDRESS:_________________________________
EFFECTIVE DATE:______________________________
CLAIM #:_____________________________
INSURANCE REP NAME:____

COVERAGE OF USUAL & CUSTOMARY CHARGES
DEDUCTIBLE AMOUNT:______________________
DEDUCTIBLE MET:_________________
LIMITATIONS OF TREATMENT:____
____
PRE-AUTHORIZATION:___________
AUTHORIZATION NUMBER:___________________
COMMENTS:____
____
____

DATE VERIFIED:_________________________________
BY WHOM:_____________________
THE PATIENT AGREES TO PAY $_____________
CO-PAY PER VISIT. DEDUCTIBLE MAY ALSO BE DUE IF NOT SATISFIED FOR THE CURRENT YEAR.
If you have any questions regarding the above benefits and/or information, please ask for clarification.
YES, I HAVE READ AND UNDERSTAND THE ABOVE STATED INFORMATION.

______________________________________ _______________________
Patient signature Date