PLEASE NOTE: THIS FORM MUST BE COMPLETED IN ITS ENTIRETY IF WE ARE TO FILE A CLAIM WITH YOUR INSURANCE. IF INCOMPLETE, YOU WILL BE CHARGED THE SELF-PAY RATE OF $65 PER SESSION AND NO CLAIM WILL BE FILED.

Insurance Benefits and Eligibility

We are pleased to provide your child with quality speech/language therapy services. We are committed to maintaining the highest standards possible for your child's optimum progress. We appreciate your business and look forward to working with you and your child!

As you are aware, as a courtesy, our office submits insurance claims for those clients who have provided their insurance information. However, your insurance company and your personal policy may not allow for coverage of services provided at our office. Please provide us with the information you have received after contacting your insurance company regarding coverage for speech therapy and or occupational therapy:

Please give your insurance company this information regarding your child:

Diagnosis code (s): ______________________________

CPT code (s): 92507

Location Code: 11

- Client Name: ______________________ Date of Birth: ______________
- Name of Primary Insurance Co.: ______________ ID #: ______________
- Phone Number for Ins Co: ______________________________
- Name of Insurance Company rep to whom you spoke and ID #: ______________
- My Insurance company stated that my policy is active as of ______________

  And that my dates of coverage are from ________ to ________
- My insurance company stated that my individual deductible for the current benefit year is $______

  I have met $ _____ of the individual deductible as of ______________
- My individual out-of-pocket expense for the current benefit year is $ ______________

  I have met $ ______ of the individual out-of-pocket as of ______________
- My family deductible for the current benefit year is $ ______________

  I have met $ ______________ of my family deductible as of ______________

- My family out-of-pocket expense for the current benefit year is $ ______________________________

  I have met $ ____________________ of my family out-of-pocket expense as of ___________________

- My deductible DOES DOES NOT apply to therapy visits.

- My insurance company has stated that my policy allows __________________# of visits in a:

  Calendar year period OR from ________ to __________ (dates)

- My visits are shared with other therapies: Yes or No If shared, with whom?

  SLP OT PT Other: ____

- I have used ____________________ # of visits as of ______________________________________

- My insurance company stated that my copay will be $ ______________ per session. (due at time of session).

- *Is a Physician's referral required: Yes or No *if yes, you are responsible for contacting your PCP.

- Is Pre-Authorization/Pre-Certification required: Yes or No If yes, please provide phone number, fax number and contact person's name to acquire authorization

  ____

  ____

- My insurance company stated that speech therapy: MAY be covered WILL NOT be covered

Please list description of what will not be covered:

____

____

- My insurance company stated speech coverage is for: Medical or Developmental

- I have a secondary insurance company: Yes or No If yes, what is the name of your secondary insurance company and id#: ____

This information is accurate as of ____________________. I am responsible for staying up-to-date regarding my insurance coverage. The above information is subject to change at any time. I must inform you immediately should my insurance coverage and benefits change. Cary Speech Services is not responsible for keeping up with any changes made by me, my employer or my insurance carrier. I will provide a copy of my insurance card(s) to Cary Speech Services for verification.

Note from Cary Speech Services:

Please remember that many insurance companies cover speech therapy only based on "medical necessity". Most insurance companies deny therapy for developmental delay. Although you, and we, can call and confirm coverage, we have experienced a significant amount of ambiguity with the information from insurance companies. **Confirmed coverage from your insurance, either verbal or in writing, in no way guarantees their payment. The only guarantee we have of coverage is their response to our direct bill.** Although we will bill insurance for every claim, you are responsible for any bills unpaid by your insurance company. We bill immediately after services but it can take 30-60 days for the insurance company to determine their payment. **We will gladly file insurance with all carriers, but you may be responsible for meeting your deductible, a co-pay or payment in full. You are ultimately responsible for knowing your insurance benefits and coverage and for meeting your deductible.**

____________________________________ ____________________

Patient Name **Date of Birth**

____________________________________ ____________________

Signature of Guarantor **Date**

875 Walnut Street Suite 275 * Cary, NC 27511 * Phone: 919-460-0113 * Fax: 919-467-1712 * Email: caryspeech@gmail.com

10/10/17 kjf