



Health Insurance Benefits Verification

We will work with you to determine your health insurance benefits and file claims on your behalf. To insure that you understand your benefits and your responsibilities, we ask that you verify them prior to your first visit. *Creative* provides integrated services that are presented as Occupational Therapy to carriers, so you will always be inquiring as to those services. (If you have more than one insurance plan, fill out one form for each plan and indicate the primary plan.)

Your Insurance carrier¹ (e.g., CareFirst, Aetna, Cigna, Anthem, etc.): _____

Subscriber (member) ID: _____ Group ID: _____

Member Services Phone: _____ Provider Services Phone: _____

Always call Member Services

Date you called: _____ To whom you spoke: _____

Request verification of eligibility and reimbursement for Occupational Therapy. Depending in the carrier we may be listed as "Creative Health Solutions" (tax id 263881004) or "Judy Feingold, OT" (tax id 208417272)

Do they cover OT? Yes ___ No ___

Is there a co-payment (fixed or percentage of the charge) ? Yes ___ No ___ If Yes, how much? _____

Is there a deductible that you must meet before the coverage begins? Yes ___ No ___ If so, how much? _____
How much have you paid so far? _____

Is there an out-of-pocket maximum after which they pay everything? Yes ___ No ___ If so, how much? _____
How much have you paid toward it so far? _____

Is there a limit to number of sessions per year? Yes ___ No ___ If so, how many? _____ How many, if any, have been used so far? _____

Is there a dollar limit to their reimbursement? If so, how much? _____

Do you need an authorization before treatment or after the first session ? Yes ___ No ___ If so, how do you get it and from whom? _____ (Note that in Virginia a referral or prescription is not medically required to see an OT; this does not eliminate insurer requirements for authorization.)

Will the carrier require information from Creative now (to initiate) or in the future (to continue) coverage? Yes ___ No ___ If so, after how many visits? _____

Information for follow up (e.g., contact and telephone) _____

I have reviewed the above information, inquired as indicated, and understand that I am responsible for co-pays, co-insurance, and deductibles for in-network service, as well as for un-reimbursed charges for out-of-network coverage.

Patient's Name: _____

Parent/Guardian Printed name: _____

Signature: _____ Date: _____

1 If your insurance is BCBS PPO out of area, please contact the Creative Health Solutions business office 703-639-4078