St. Vincent Hospital

Insurance Eligibility and Benefits Form

❑ **Primary Commercial Insurance: _____ ID# _____**
Date: _____ Phone # _____ Name of Representative: _____
Reference #: _____

According to insurance company:	Effective date: _____
❑ Pt is/is not eligible for PT/OT/SLP benefits at this time ❑ St. Vincent OP services are in/out of network ❑ Authorization is/is not needed ❑ Referral is/is not required	Policy plan restarts on: _____

Patient's Responsibility
You have met $_____ of your $_____ deductible. You have paid $_____ towards your max out of pocket of $_____.

- ❑ You have a $_____ co-pay due for each visit
- ❑ You have a _____% co-insurance due for each visit.
  - Estimated amount for initial evaluation: _____% x $144 = $_____
  - Estimated amount for follow-up visit: _____% x $80 = $_____

You have a PT benefit limit of _____# visits per policy year. You have already used _____ visits.

Other relevant plan benefit information:

❑ **Secondary Insurance: _____ ID# _____**
Date: _____ Phone # _____ Name of Representative: _____
Reference #: _____

Other relevant plan benefit information:

❑ **MEDICARE ID# _____**
Date: _____ Phone # _____ Name of Representative: _____
Reference #: _____

You have a total amount of $_____ for physical therapy benefits this calendar year. You have already used $_____.

❑ **Secondary Insurance: _____ ID# _____**

- ❑ Your secondary insurance will cover the remaining 20% co-insurance not covered by Medicare.

❑ **MEDICAID ID# _____**
Date: _____ Phone # _____ Name of Representative: _____
Reference #: _____

You have a total amount of 48 units of physical therapy benefits for this 12-month period. You have already used _____units.

Please be informed that St. Vincent Physical Therapy collect all known payments at time of service.

Patient Signature: _____ **Patient Printed Name:_____**