COORDINATION of BENEFITS / LIABILITY INFORMATION

Your insurance carrier may require additional information before they are able to complete claims processing.

NKC OP IND SKC KCK TOP LIB STJ OLA SPGF WW SHW WE LS DESM ANK BS URB LEN MID

Re: Physical and/or Occupational therapy visits beginning _____________

Patient's Name: _________________________________ Date of Birth: _______________

Part of body being treated: ______________________________________

Name of Primary Insurance Carrier: _______________________________________

Is the patient covered under any other insurance policy? Please circle: Yes No

If yes, please provide name of other insurance carrier: ___________________________________

If the claim is for a dependent child, is the child enrolled as a full time student? Yes No N/A

Do you remember a specific incident that caused your condition? Please circle: Yes No

If yes, what was the **date** it happened? _________________

How did it happen? ____

____

Where did it happen? ____

If you don't recall any specific incident, what was the date of the onset of symptoms? _______________

Is this work related? Please circle: Yes No

If yes, have you filed or will you file a claim under worker's compensation? Yes No

If this is work related, but you have not filed a worker's compensation claim, please explain why:

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____

Is there any third party liability involved? Please circle: Yes No
(Another party responsible for payment)

If yes, please give details below:

Name of responsible party: _________________________________

Insurance company of responsible party: ______________________

Claim adjuster's name: __________________________________

Adjuster's phone number: _________________________________

Claim number: ____

Certification of Statements:

I certify that all of the above statements are correct.

_____________________________________ _______________
Signature of Patient or Guardian Date