ARC | Physical Therapy+™

COORDINATION of BENEFITS / LIABILITY INFORMATION

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

NKC IND SKC KCK TOP LIB OP STJ OLA SPGF WCHT

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:

_____

_____

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