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Insurance Benefits Checklist

When calling your insurance company to verify your benefits, ask the following questions:

1. Do I have “out-of-network” physical therapy benefits? Yes / No
   (If yes, proceed to the following questions)

2. What is my out-of-network deductible? _____

3. What is my out-of-pocket maximum? _____

4. What is my coinsurance?_____

5. Do I have a visit limit? _____

6. Do I need pre-authorization? Yes / No
   a. If yes, how do I obtain pre-authorization? _____

7. Do I need a referral? Yes / No

8. How do I submit a claim?_____

(Also, there is an app called “Reimbursify” that may help you submit your claim as well)

Notes:

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What do these terms mean?

• Deductible: The amount of out-of-pocket costs you will need to incur before the insurance plan will reimburse you

• Out-of-pocket maximum: The amount of out-of-pocket costs you need to incur before the insurance plans covers all services at 100%

• Coinsurance: The percentage of the billed cost of services you owe after the insurance plan covers their portion. The representative may state that your plan will cover up to 70%, which means you should expect to get 70% of the cost of the session reimbursed to you in a check.

• Visit limit: The number of therapy visits you have per year. It may be expressed per calendar year or over a different 12-month period. Sometimes it will be “based on medical necessity,” which means there is no limit, as long as the services are deemed medically necessary.

• Pre-authorization: Sometimes, plans require the provider to obtain authorization for certain procedures and over a certain period of time before starting PT services.

• Referral: A physician prescription. We have direct access in Oregon State, which means that you don’t need a referral to start care. However, some insurance plans still require that you have a referral on file.