Insurance Verification for Orthotics Form

DATE & TIME OF CALL: _____

PATIENT NAME: _____

PROCEDURE: _____ _____

PROCEDURE CODE: _____

DIAGNOSIS: _____

DIAGNOSIS CODE (S):_____

DEDUCTIBLE: $_____ HOW MUCH MET: $_____

COVERAGE: _____PERCENT

DO I NEED A LETTER OF MEDICAL NECESSITY: _____

DO I NEED A PRESCRIPTION: _____

IS PRE-CERTIFICATION REQUIRED: _____

AM I COVERED TO RECEIVE TWO PAIRS PER YEAR: _____

NAME OF PERSON CONTACTED: _____

REFERENCE # FOR PHONE CALL: _____

ORTHOTICS DEVICES MAY BE CONSIDERED “DURABLE MEDICAL EQUIPMENT”

I WANT TO RECEIVE CUSTOM MOLDED FOOT ORTHOTICS. SHOULD MY INSURANCE CARRIER DENY PAYMENT, OR STATE THAT ORTHOTICS IS NOT A COVERED BENEFIT, I FULLY UNDERSTAND AND PERSONALLY AGREE TO ACCEPT RESPONSIBLITIY FOR PAYMENT OF THE CHARGES.

_____ _____

DATE RESPONSBILE SIGNATURE