865PT
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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?

_____

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 insurance plan covers their portion. The representative may state that the plan will cover up to 70%, which means you should expect

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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 Tennessee, which means that you don't need a referral for the first 10 visits or first 90 days of treatment, whichever comes first. However, some insurance plans still require that you have a referral on file.

If you have any additional questions, please reach out via email at office@865pt.com or call 865.217.6373