Caring Hands Physiotherapy

Direct Electronic Claim Submission Authorization Form

Patient Name: _____ Date of Birth (mm/dd/yyyy) _____

Are you involved in Motor Vehicle Accident ☐ Y ☐ N.If yes, Date of MVA (mm/dd/yyyy) : _____

Name of Primary Extended Health Benefits Insurance company: _____

Primary Member name_____ Date of Birth (mm/dd/yyyy) _____

Policy/ Group/ Contract no _____ ID: _____

Coverage Period: Start month_____ End Month_____

Max Coverage

Physiotherapy: $ / % _____ / year or per visit

Massage: $ / % _____ / year or per visit

Chiropractor: $ / % _____ / year or per visit

Acupuncture: $ / % _____ / year or per visit

Secondary Insurance (Spouse Insurance or secondary coverage): _____

Primary Member name_____ Date of Birth (mm/dd/yyyy) _____

Policy/ Group/ Contract no _____ ID: _____

Coverage Period: Start month_____ End Month_____

CONSENT

I hereby certify that _____has been authorized to submit claims on my behalf to my Insurance company and the Information contained in the claims is complete and accurate.

I understand that I may have to co-pay if my insurance only covers some portion of total expense or has Coordination of Benefits.

I understand that I am fully responsible to make full payment if my insurance company denies my claim.

Signature: _____ Date: _____