

Blue Cross and Blue Shield Plans
PRE-CERTIFICATION INSURANCE QUOTE
Advanced Physical Therapy Center of Stamford, LLC

As of _____ your insurance carrier “quoted” your benefits for physical and/or occupational therapy:

Deductible \$ _____ Co-insurance _____% Co-payment \$ _____ each visit
Re-evaluation \$ _____ Initial evaluation \$ _____

Under Connecticut law and nationally established standards of practice, every patient must undergo an initial physical therapy evaluation and periodic re-evaluations. However, some BC/BS Plans **will not cover re-evaluations** and will only cover **one initial PT evaluation every 180 days** regardless of the diagnosis. Therefore, you will be financially responsible for these charges. Please be advised that your insurance carrier also states they “are not responsible for the accuracy of this information” and that this quote of benefits “is not a guarantee of payment”. **As a result, you will be held financially liable if your insurance company denies payment for services rendered at Advanced Physical Therapy Center of Stamford, LLC. Therefore, you may also want to verify your benefits by calling the 800 number on your insurance card.**

LIMITATIONS

In order to *minimize the chance* that your insurance company will reject your claim for therapy at our office, we request you provide the following information. Your policy may have specific limits of coverage and therefore, we ask these questions to help uncover any potential limitations with your specific insurance plan. **Failure to respond accurately may result in your insurance company denying payment, thus you will be help financially responsible for services rendered to you by Advanced Physical Therapy Center.**

- | | | |
|--|-------|----|
| 1. Have you received physical therapy in the past 12 months? | Yes | No |
| If so, for the same diagnosis or body part? | Yes | No |
| How many visits did you attend? | _____ | |
| 2. Have you received occupational therapy in the past 12 months? | Yes | No |
| If so, for the same diagnosis or body part? | Yes | No |
| How many visits did you attend? | _____ | |
| 3. Have you received chiropractic in the past 12 months? | Yes | No |
| If so, for the same diagnosis or body part? | Yes | No |
| How many visits did you attend? | _____ | |

Payment Policy:

All payments (deductibles, co-insurance and co-payments) are due at the time of service.

Patient’s Signature

Date

Guardian’s Signature

Date

APTC Rep.

DO NOT CASH CHECK: IN THE EVENT YOU RECEIVE PAYMENT DIRECTLY FROM BLUE CROSS/BLUSE SHIELD, YOU **MUST SURRENDER THE CHECK AND COPY OF THE “EXPLANATION OF BENEFITS”** TO OUR OFFICE IMMEDIATELY. FAILURE TO DO SO MAY RESULT IN FINES, PENALTIES, ADDIONAL TAX LIABILITY OR POSSIBLE LEGAL PROSECUTION.