



At Aspire Health & Wellness, we do not want the high costs of healthcare and obscure policies of insurance companies to affect your road to recovery. As such, we work hard to keep costs low and empower you with the knowledge to understand your insurance policy. Below is a list of detailed questions you should ask your insurance company's customer service representative in order to figure out your specific benefits for physical therapy:

1. Call the Customer Service Phone Number (i.e. 1-800-xxx-xxxx) located either on the front or back of your insurance card.

Say: "I'm calling to verify my out-of-network benefits for outpatient physical therapy."

Note:

- "Outpatient physical therapy" is also called "in office."
- Aspire Health & Wellness is **NOT** considered "in facility." "In facility" means in the hospital.
- Aspire Health & Wellness is "out-of-network," also known as a "non-preferred provider."

2. **What is my deductible?** (Individual) _____ (Family) _____
3. **How much has been met?** (Individual) _____ (Family) _____
4. **What is the rate of coverage/ co-insurance?** _____

Here, you will be told something like, "the visit will be covered at 70% of the allowed amount." This means that your financial responsibility will be 30% of the day's total charges. Some common rates of coverage are 90/10, 80/20, or 70/30.

5. **What is my co-pay?** _____

If you have a deductible, this co-pay will kick in once the deductible has been met.

6. **How many visits are allotted per calendar year?** _____

Usually physical therapy is combined with occupational therapy, chiropractic care, speech therapy, etc.

7. **How many visits have been used so far?** _____

8. **Do the visits start counting before or after the deductible has been met?** _____

9. **Are there any limitations per visit of physical therapy? For example, a limit on the number of modalities that can be performed per day or per visit? A dollar amount covered per day/ per visit?**

10. **Is pre-certification or pre-authorization required? If so, what is the phone number that I call?**

11. **Where should I submit my claims?** _____

12. **Is there a call reference number for this call?** _____

13. **Is a prescription required?** _____

14. **Any additional comments:** _____

Name of representative: _____

Date: _____

Time of call: _____

*****A verification of benefits does not guarantee payment or coverage of services rendered.*****