

Staff Documentation

MD – Next Appt ____ - ____ - ____

MD – Last Appt ____ - ____ - ____

Reviewed ALL Accounts in RXNT? YES

NO – if no, do not rely on what patient wrote below

Date “clipped” to all pts ____ - ____ - ____

Benefits done by: _____

Date completed ____ - ____ - ____

Date Emailed to all Billers ____ - ____ - ____

Circle Biller you Emailed:

GENA PAM HEATHER TARA AMY BRITTANY LAUREN

Billers Past Dates Rebilled? YES NO N/A

Today’s Date: ____ - ____ - ____

To be completed by Responsible Party/Patient

List below all family members affected by this change of insurance that are seen at PRA!!

1. _____ 2. _____
patient first name last date of birth patient first name last date of birth

3. _____ 4. _____
patient first name last date of birth patient first name last date of birth

Effective Date of policy: ____ - ____ - ____

Check ALL clinicians affected by this insurance change

- Perakis Resis Woods Paul Fabsik Womack Schoenbrod McFaul Godfrey Chang Nawaz Rhee Gorman Benson

Therapist(s) List name(s): _____

Do you want a call regarding new benefits? Yes No Phone #: _____ to call with results.

Relation to the Policy Holder: self spouse child other

Policy Holder’s Name: _____ Policy Holder’s D.O.B: ____ - ____ - ____

Policy Holder SS# _____ - _____ - _____ ***Must be completed!*** Group #: _____

Name of Insurance: _____ ID# _____ Insurance Phone #: _____

Policy Holder’s Place of Employment: _____

Failure to complete ALL this information may result in insurance not being changed in our system timely, could result in services denied if precertification was not obtained prior to change of insurance and may result in full payment due by patient! 6/19