NEW INSURANCE FORM

Today's Date: _____-_____-_____ Completed by ☐Patient ☐ Staff/Clinician Initials _____

☐ Current Patient - Insurance Change ☐ Returning Patient

BELOW INFORMATION - 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

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Effective Date of policy: _____-_____-_____

Check ***ALL*** clinicians affected by this insurance change

☐ Resis ☐ Woods ☐ Paul ☐ Fabsik ☐ Schoenbrod ☐ McFaul ☐ Godfrey ☐ Chang

☐ Nawaz ☐ Rhee ☐ Gorman ☐ Komarovsky ☐ Iqbal ☐ Greenwald

☐ 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! * Policy Holder Phone #: (_____) _____-_____**

Name of Insurance: _____ ID#_____ Group #: _____

Insurance Phone #: (_____) _____-_____ Policy Holder Place of Employment: _____

Secondary Insurance? ☐ No ☐ Yes – complete below

2nd Insurance Name: _____ ID #:_____ Group #:_____

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! 10/1/20

STAFF DOCUMENTATION ONLY BELOW

Returning Patients –Demographics on EMR are verified and accurate by front desk? ☐Yes ☐No – why not???

MD – Next Appointment _____-_____-_____ **MD** – Last Appointment _____-_____-_____

Reviewed ALL account in BILLING? ☐Yes ☐ No (others who need updated benefits)

Date Up-loaded into EMR _____-_____-_____ New PT for Therapist up-loaded to share file. ☐

Benefits done by: _____ **Date Completed**: _____-_____-_____

Date Billers notified/emailed: _____-_____-_____ **Date Therapist called with benefits**: _____-____-_____

Billers – Contact patients for any issues with new insurance ☐ Yes ☐ No – no issues with benefits

Billers – For new insurance – Any Past DOS need to be rebilled? ☐ Yes ☐ No ☐ N/A

Billers – PT Accounts updated in all EMR Date:_____

Billers emailed: ☐ Susan ☐ Heather ☐ Tara ☐ Amy ☐ Brittany ☐ Lauren ☐ Other_____

Comments: