**Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date of Birth (MM/DD/YYYY):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Name of the **Primary** Insurance Company: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Primary Policy Holder Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth (MM/DD/YYYY):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy ID/Claim #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Group ID: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Do you have any other/secondary Extended Health Benefit***? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of the **Secondary** Insurance Company: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Secondary Policy Holder Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth (MM/DD/YYYY):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy ID/Claim #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Group ID: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Assignment of Benefits Needed? Yes / No

Coverage Period Start: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ End: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Physiotherapy Coverage*:**

Max Limit: $\_\_\_\_\_\_\_\_\_\_Percentage covered each visit: \_\_\_\_\_\_\_\_\_ Deductibles: \_\_\_\_\_\_\_\_\_\_\_\_

Does your Insurance required a Doctor’s referral for Physiotherapy e-Claims? Yes/No

* If Yes, Physicians Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Referral\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Massage Coverage***:

Max amount Limit: $\_\_\_\_\_\_\_\_Percentage covered each visit: \_\_\_\_\_\_\_\_\_ Deductibles: \_\_\_\_\_\_\_\_

Does your Insurance required a Doctor’s referral for Physiotherapy e-Claims? Yes/No

* If Yes, Physicians Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Referral\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Custom Foot Orthotics:***

Max amount Limit: $\_\_\_\_\_\_\_\_Percentage covered each Year: \_\_\_\_\_\_\_\_\_ Deductibles: \_\_\_\_\_\_\_\_

Doctor’s referral provided for Custom foot Orthotics? Yes / No

If Yes, Physicians Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Referral\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Did you apply for Custom foot orthotics earlier to your Insurance? Yes/No

* If Yes, Please provide the date of Service\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**CONSENT**

* **I hereby certify that Genesis Physiotherapy Centre 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 am responsible to pay the co-payment, if applicable, at the time of each appointment.**
* **I understand that I am fully responsible to make full payment, if my insurance company denies my claim.**

**Signature**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_