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INSURANCE VERIFICATION

Date: _____ Patient's Name: _____

Insurance Company: _____ Phone #: _____

Member Name _____ Member DOB _____

Member ID _____ Group ID _____ Effective Date _____

Spoke to: _____

Deductible: Individ. \$ _____/Fam. \$ _____ Amt Met: Individ. \$ _____/Fam. \$ _____

Co-Pay: \$ _____ Co-insurance: _____% Lifetime Max: \$ _____

Does tx need to be pre-certified? _____

of ST Visits: _____ # of ST Visits Used: _____ \$ Limit on ST Svcs Used: _____

Covered DX Codes: _____

Is Developmental Delay a covered service? _____

Exceptions: _____

of OT Visits: _____ # of ST Visits Used: _____ \$ Limit on ST Svcs Used: _____

Covered DX Codes: _____

Is Developmental Delay a covered service? _____

Exceptions: _____

of PT Visits: _____ # of ST Visits Used: _____ \$ Limit on ST Svcs Used: _____

Covered DX Codes: _____

Is Developmental Delay a covered service? _____

Exceptions: _____

Verified by: _____ Date: _____

Please feel free to ask questions regarding this statement. I have read the insurance verification and I understand these benefits are not guaranteed, they are an estimate from my insurance company. My co-payments are due at the time of service and my percentage of financial responsibility is due at the end of each visit unless prior arrangements have been made with the billing department. If I owe more than the insurance company originally quoted, I will be responsible for that amount. If I over-pay the bill, I will be reimbursed the amount that I overpaid.

Parent/Legal Guardian: _____ Date: _____

AFK Representative: _____ Date: _____

Tx=therapy ST=speech therapy OT=occupational therapy PT=physical therapy DX=diagnosis