



INSURANCE CHECK

Phone Number Called: _____ Date: _____ Time: _____

Person making the call: _____ Person talked to: _____

Number of visits allowed: _____ Any deductible: \$ _____

Deductible already met? If only partially, balance \$ _____

Co-payment if any: _____

What Documentation will they require as part of billing: _____

In case patient has Blue Cross Blue Shield of Michigan and PT is not covered in Free Standing Facility (OPT), ask if the patient has Master Medical Coverage. (Co-payment and deductible for MM)

Any other information provided such as mailing address etc. _____
