NEURODEVELOPMENTAL THERAPY SERVICES, INC.
4423 Shadowdale • Houston, TX 77041-8718 • Ph: # 713-466-6872 • Fax: #713-466-9547

INSURANCE AGREEMENT AND VERIFICATION–2020

DATE: _____

CLIENT'S NAME: _____ MEMBER #: _____
CLIENT'S DOB: _____ GROUP #: _____
INSURANCE COMPANY: _____ PHONE #: _____
VERIFIED BY: _____ INSURED: _____
CLAIMS ADDRESS: _____ INSURED'S DOB: _____
_____ INSURED'S SS #: _____
PAYOR ID: _____
SPOKE TO: _____
CALL REFERENCE #: _____
E-MAIL ADDRESS: _____
IN-NETWORK YES/NO POS/HMO/PPO/OTHER_____

COVERAGE PT____OT____ST____

EFFECTIVE DATE: _____ # OF VISITS: _____
CO-PAY: _____ DEDUCT: _____
YEAR STARTS: _____ DEDUCT MET: _____
OUT OF POCKET: _____ AMT APPLIED: _____
AMOUNT APPLIED: _____ PRECERT/REFERRAL AUTH: _____
_____

COMMENTS: _____
_____

LMN_____EVAL_____AFTER VISIT # _____

Please be aware that certain therapy procedures or services may not be covered or may be considered "not medically necessary" or "experimental" by your health plan. You are responsible for payment of these services. **Please also be aware that many health plans limit therapy coverage. *In the event your care exceeds a plan limitation, you will be responsible for the balance*. It is your responsibility to know your benefits and limitations of your current health care coverage. NTS will provide medically necessary care based on a client's medical needs, not a client's insurance coverage. NTS is not responsible for knowing your plan's specific benefit and coverage limitations. All co-pays and deductibles will be collected at time of service, including those with secondary insurance coverage. You will be refunded once payment is received from your secondary insurance.**

I have read and understand the above information. I agree that I am ultimately responsible for payment of services rendered by NTS or its agent.

X _____ DATE: _____
RESPONSIBLE PARTY

X _____ DATE: _____
NTS REPRESENTATIVE