



**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 \_\_\_\_\_  
RESPONSIBLE PARTY

DATE: \_\_\_\_\_

X \_\_\_\_\_  
NTS REPRESENTATIVE

DATE: \_\_\_\_\_