Patient Eligibility

In order to determine benefits, please complete the information below and attach a copy of your insurance card front and back.

Patient Name:___________________________________ DOB:______________

Insurance Co:_________________________________ Ph. #:_________________

Insurance ID____________________________________

Insured Name:__________________________________ DOB:_______________

Diagnosis:____

***MEDICAL BILLING**: Please complete **ALL** portions of eligibility form*

and return to TC (fax 361-853-7216 or scan/email to therapyconnections@att.com)

DETERMINATION OF BENEFITS

Copay: no yes $___________ Deductible: no yes $_________________

Patient share: no yes $_______________ Preauthor. Required: no yes

Assessment report required for preauth/authorization of services: no yes

CPT____________ max allowable time/charge _________/$_____________

Visit Limit: no yes__#________________________

CPT/direct service- clinic: __________ school:_________home:__________

Authorization (date) from:______________ to:_________________

Progress notes required for renewal: no yes

CPT____________ max allowable time/charge _________/$_____________

Reference #____

Notes:

1001 Louisiana Ave., Ste. 200 * Corpus Christi, TX 78404
Phone 361-815-2433 * Fax 361-853-7216
www.therapyconnectionsofsouthtexas.com