INTENSIVE THERAPY PAYMENT

Please read through this information thoroughly. It has been compiled to assist you in payment of your child's Intensive Therapy Session.

OUR THERAPISTS

Intervention is provided by experienced and Therasuit® Certified Physical Therapists and Occupational Therapists that are licensed in the state of Florida in their area of specialty.

Billing/Insurance

Our Office will submit for authorization for your child for the intensive program frequency and duration that has been recommended at their initial evaluation. You will be notified within 14 business days of what has been authorized by your insurance plan and an estimate of your financial responsibility in the event your insurance does not cover the full program.

Most insurance companies have limitations on how many sessions of therapy they will cover each year. Please clarify your benefits so that when your insurance is billed for the service, you will still have additional sessions to last the remainder of the year.

Requesting a case manager through your insurance has been known to improve your chances for reimbursement for the Intensive Therapy Program. When possible, contacting your insurance company at least three months prior to attending the Intensive Therapy Program if possible is strongly advised. This allows time for you to submit documentation and get approval from your insurance.

In the event that you do not have insurance, we do offer a self-pay option. Please call our office for more information.

Funding Opportunities for families:

United Healthcare Children's Foundation **https://www.uhccf.org/** (must have a commercial primary insurance- may have Medicaid secondary)

The LENN Foundation https://thelennfoundation.org/

First Hand Foundation https://www.firsthandfoundation.org/

NICA https://www.nica.com/

Gardiner Scholarship http://www.fldoe.org/schools/school-choice/k-12-scholarship-programs/gardiner/

Insurance/ Guarantor Information Child's

Child's Name:_____Birthdate:_____Age:_____ Sex: ↑M↑F
Address:_____City:_____State:_____ZiP :_____
Mother's Name:_____ Home Phone:_____ Cell Phone: _____
Father's Name:_____Home Phone:_____ Cell Phone: _____

Primary Insurance Name: _____ Insurance Phone #:_____
Insurance claims Address: _____
Policy #: _____ Group Name: _____Group #: _____
Policy Holder Name: _____ Birthdate: _____Effective date: _____
Secondary Insurance Name: _____ Insurance Phone #: _____

Insurance claims Address: _____
Policy #: _____ Group Name: _____Group #: _____
Policy Holder Name: _____ Birthdate: _____Effective date: _____
Medicaid #: _____

Billing Policies / Assignment of Benefits

1. We will bill your insurance as a courtesy to you. However, it is your responsibility to assist in the prompt receipt of payment from your insurance company.

2. Please inform us of any changes in private insurance or Medicaid coverage. Failure to notify us on changes may result in parent or legal guardian being responsible for payment.

3. Parent or legal guardians are responsible for payment of services if insurance or secondary plan coverage is terminated.

4. Any invoice that is not paid within 30 days will receive a phone call or follow-up invoice. Any invoice not paid within 90 days will be turned over to our collection agency.

I understand and accept the billing policies and procedures listed above and authorize payment of medical benefits and /or government benefits to Baptist Health, Inc.

_____ _____

Parent or legal guardian Date of signature