

Mark Farris Pirtle, DPT, CSCS, COMT Medical Insurance Reimbursement Form

Patient's Full Name:	Social Security Number:
Address: _____	Phone numbers: Home: _____ Cell: _____ Fax: _____

Description of Expenses
Indicate each expense on a separate line

Health Care Expenses

Date of Service	Type of Service	Total Amount per Service Date
	Physical Therapy (see record attached)	
	Physical Therapy (see record attached)	
	Physical Therapy (see record attached)	

Reimbursement Request Instructions:

Please read these instructions before completing the Reimbursement Request Form:

1. Complete all information requested in each section.
2. For expenses that are payable by any benefit plan, attach a copy of the plan's *Explanation of Benefits* (EOB) to this form.
3. For expenses not covered under any benefit plan, attach a copy of the paid itemized bill to this form.
4. Please attach a physician's prescription for insurance payors who require a physician's prescription before payment of physical therapy services
5. Read the Certification for Reimbursement statement at the bottom of this form, then sign and date the form in the space provided.
6. Mail the completed form and applicable attachments to your medical insurance provider.

CERTIFICATION FOR REIMBURSEMENT:

I certify that the expenses for reimbursement requested in this form were incurred by me (or my eligible dependent(s)), have not been paid, were not reimbursed by any other plan, and, to the best of my knowledge and belief, are eligible for reimbursement under my current medical insurance policy.

Patient (or guardian) Signature: _____ Date: _____