Out-of-Network Insurance Benefits Checklist

When calling your insurance company to verify your benefits, select the option to speak with a customer service representative and ask the following questions:

1. Do I have “out-of-network” physical therapy benefits? ☐ Yes ☐ No
    1. If yes, proceed to the following questions
2. Do I have an out-of-network deductible? ☐ Yes ☐ No
    1. If yes, what is my out-of-network deductible? _____
    2. How much of my deductible has been met? _____
3. What is my out-of-pocket maximum? _____
4. What is my coinsurance? _____
5. Do I have a visit limit? ☐ Yes ☐ No
    1. If yes, how many visits per year? _____
    2. Is that a calendar year? ☐ Yes ☐ No
    3. If no, is it a 12-month period and what are the start/end months? _____
6. Do I need authorization prior to beginning physical therapy? ☐ Yes ☐ No
    1. If yes, how do I obtain prior authorization? _____
7. Do I need a written referral from my doctor? ☐ Yes ☐ No
    1. If yes, does my referral need to come from my primary care doctor? ☐ Yes ☐ No
8. Is there a special form I need to submit to be reimbursed? ☐ Yes ☐ No
    1. If yes, where is the form? _____
    2. What is the mailing address the form should be sent to? _____

What do these terms mean?

- Deductible: The amount of out-of-pocket costs you will need to incur before the insurance plan will reimburse you
- Out-of-pocket maximum: The amount of out-of-pocket costs you need to incur before the insurance plan covers all services at 100%
- Coinsurance: The percentage of the billed cost of services you owe after the insurance plan covers their portion. The representative may state that the plan will cover up to 70%, which means you should expect to get 70% of the cost of the session reimbursed to you in a check.
- Visit limit: The number of therapy visits you have per year. It may be expressed per calendar year or over a different 12-month period. Sometimes it will be “based on medical necessity,” which means there is no limit, as long as the services are deemed medically necessary.
- Pre-authorization: Sometimes, plans require the provider to obtain authorization for certain procedures and over a certain period of time before starting physical therapy services.
- Referral: A physician prescription. We have direct access in Oregon, which means that you don’t need a referral to be seen for physical therapy treatment. However, some insurance plans still require that you have a referral on file.

If you have any additional questions, please reach out via email at info@orchardbend.com or call 541-728-3559.