
DIRECT ELECTRONIC CLAIM SUBMISSION AUTHORIZATION

Client's Name: _____ Date of Birth (mm/dd/yy): _____

Name of **Primary** Insurance Company: _____

Primary Policy Holder Name: _____ Date of Birth (mm/dd/yy): _____

Policy No./Claim No.: _____ Group ID / ID No.: _____

Do you have any other/secondary extended health benefits? ☐ Yes ☐ No

Name of **Secondary** Insurance Company: _____

Secondary Policy Holder Name: _____ Date of Birth (mm/dd/yy): _____

Policy No./Claim No.: _____ Group ID / ID No.: _____

Assignment of Benefits Needed? ☐ Yes ☐ No

Coverage Period Start Date: _____ End Date: _____

PHYSIOTHERAPY COVERAGE

Max Limit: \$ _____ Percentage covered each visit: _____ Deductibles: _____

Does your insurance require a doctor's referral for Physiotherapy e-Claims? ☐ Yes ☐ No

If yes, Physician's Name: _____ Date of Referral (mm/dd/yy): _____

MASSAGE COVERAGE

Max Limit: \$ _____ Percentage covered each visit: _____ Deductibles: _____

Does your insurance require a doctor's referral for Massage e-Claims? ☐ Yes ☐ No

If yes, Physician's Name: _____ Date of Referral (mm/dd/yy): _____

CUSTOM FOOT ORTHOTICS

Max Limit: \$ _____ Percentage covered each year: _____ Deductibles: _____

Doctor's referral provided for custom foot orthotics? ☐ Yes ☐ No

If yes, Physician's Name: _____ Date of Referral (mm/dd/yy): _____

Did you apply earlier to your insurance for custom foot orthotics? ☐ Yes ☐ No

If yes, please provide the date of service: _____

CONSENT

- I hereby certify that East Hills Physiotherapy & Massage Clinic has been authorized to submit claims on my behalf to my insurance company and the information contained in the claims is complete and accurate
- I am responsible to pay the co-payment, if applicable, at the time of each appointment
- I understand that I am fully responsible to make full payment if my insurance company denies my claim

Client's Signature: _____ Date: _____

EAST HILLS PHYSIOTHERAPY & MASSAGE CLINIC

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