M.O.S.T.
Metro Orthopedics & Sports Therapy

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Office Use Only

OV____ PT____

PIP VERIFICATION

Today's Date: __________

Patient's Name: ______________________________Account#: ________________

In order to file for reimbursement for services rendered our office must have the following information:

Claim#: ________________________________Date of Injury: _________________________

Diagnosis: _____________________________Treatment Plan: _________________________

Insurance Company: ____

Claim Representative: ____

Address: ____

_______________________________Phone: ______________________________

Approval: [ ] Yes [ ] No Date: ______________________

Specific Remarks: ____

Medical Insurance: ____

Policy #: _______________________ Group #: ______________________________

Under Litigation: [ ] Yes [ ] No

Authorization and Assignment [ ] Yes [ ] No

Attorney: ________________________________Phone #: ____________________

Address: ____

Without this information, we will be unable to collect payment for services rendered from the PIP carrier.

If you do not supply us with this information and if the PIP carrier and/or your employer's insurance company deny your claim, you will be held responsible for payment of your bill.

Signature:_________________________________ Date:____________________

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