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Protocol for patient initial call and appointment set-up
Please circle one of the following: **NP** or **RPTE**
Patient Name (*Correct Spelling*): _____
Home Phone Number: _____ Cell Number: _____ Work Number: _____

Body Part/DX: _____
Surgery (if yes what type): yes no _____ Date of Surgery: _____

Referring MD: _____ Who at the MD office told you about us: _____
Primary Care MD: _____ Who at the MD office told you about us: _____
If patient isn't referred by M.D., how did they hear about Reddy-Care PT: _____
Let patient know to bring prescription and/or referral from referring/primary M.D.
Have you ever had PT anywhere else: **YES NO** Was it for this condition: _____ What was the outcome: _____

Primary Insurance : _____ Insurance ID #: _____ Pt. DOB: _____
Secondary Insurance : _____ Insurance ID #: _____ Pt. DOB: _____
If WC/NF: Carrier Name: _____ Phone #: _____
Claim #: _____ Injury Date: _____

Who took the call: _____ Date of the Call: _____
Day Scheduled: _____ Time Scheduled: _____ PT Assigned To: _____
If not scheduled, reason: _____

**** PLEASE INFORM PATIENT TO ARRIVE 20 MINUTES EARLY FOR PAPERWORK!****
Do you have directions? (Give Directions)
Cash, Check, or Credit Card for Co-payments only
Parking –there is plenty of street parking and parking on the west side of the building
Make sure that you wear comfortable clothing
Bring photo ID, Ins Card(s), and Rx from referring doctor, X-Rays/Surgical/MRI reports
Bring your calendar if needed to book your appointments

Primary Insurance Benefits

In Network Benefits

Insurance Carrier: _____ PH #: _____
Copayment: _____ Coinsurance: _____ # Visits/year: _____ # Visits Used: _____
Deductible (Ind/Fam): _____ Deductible Met (Ind/Fam): _____
Referral Required: **Yes No** Precert Required: **Yes No** Precert Info: _____
Out of Pocket Max: _____ Out of Pocket Max Met: _____

Out of Network Benefits

Copayment: _____ Coinsurance: _____ # Visits/year: _____ # Visits Used: _____
Deductible (Ind/Fam): _____ Deductible Met (Ind/Fam): _____
Referral Required: **Yes No** Precert Required: **Yes No** Precert Info: _____
Out of Pocket Max: _____ Out of Pocket Max Met: _____
Specific out of net benefit (insurance reimbursement/patient responsibility, Reasonable/Customary?, MNRP)

Rep Spoke to : _____ Reference #: _____ Employee Initials Verified by: _____

WC / NF Insurance Benefits

Claim open: _____ Active: _____

Any negatives against claim: _____

Adjustor: _____

Phone #: _____ Fax Number for Auth: _____

Mail Claims :

MCR

A: MCR Primary: YES NO
B: Advantage: YES NO
2011 Ded: Home Health: YES NO
2011 Cap: Hospice: YES NO

Secondary Insurance to MCR:

Pick up 20 % of co-insurance that MCR doesn't pay?
Pick up MCR part B deductible?
Auto-cross over?
Copay?
Deductible?
Take over as primary insurance if MCR denies? Benefits?
Coordination of Benefits? (write details in notes below)

Notes:

(After 2 phone calls with no contact or a n/c patient — pass intake to VPA, VPPR, or CEO to follow up with)

