Skills on the Hill
PEDIATRIC OCCUPATIONAL THERAPY

REQUEST FOR INSURANCE VERIFICATION

(The following information is needed so benefits for OT can be verified.)

FAX or email this information to: Skills on the Hill Insurance and Benefits Verification

Fax: **301-668-7008** Email: skills@hspmd.com

Main Concern / Diagnosis: _____

Child's Name: _____ Date of Birth:_____

Address:_____

_____

Your name to discuss benefits: _____

Your relationship to the child: _____

Best number to reach you: _____ mobile ☐ home ☐ work ☐

Email: _____ Subscriber DOB (P)_____ Subscriber DOB (S)_____

***** The subscriber's date of birth is required for insurance claim submission. Please provide Primary (P) and Secondary (S) information**

Does your child have secondary insurance? ☐ **YES** ☐ **NO**

You may send a front/back copy of the card rather than fill out the insurance information below.

Primary Insurance Company Name: _____

Subscriber name: _____ Date of Birth_____
(Required) **(Required)**
Insurance ID Number: _____ Group #_____

Claims mailing address:_____

Claims contact telephone number: _____

Secondary Insurance Company Name: _____

Subscriber name: _____ Date of Birth_____
(Required) **(Required)**
Insurance ID Number: _____ Group #_____

Claims mailing address: _____Telephone: _____

Comments:

405 8th St, NE Ste 301
Washington, DC 20002
202.544.5439

Benefits Verification
202.424.2718

3508 Lee Highway Ste 100
Arlington, VA 22207
703.243.4601