



**EXPLANATION OF BENEFITS:**

The following is a list of benefits as quoted to Lewy Physical Therapy from your insurance company  
This is not a guarantee of payment. Your benefits apply to the item checked.

**DEDUCTIBLE**

Amount: \$ \_\_\_\_\_ Amount met \$ \_\_\_\_\_

Your insurance pays \_\_\_\_\_% and you are responsible for \_\_\_\_\_% after deductible.

Estimated co-insurance collected each visit \$ \_\_\_\_\_.

**OUT OF POCKET**

Amount: \$ \_\_\_\_\_ Amount met: \$ \_\_\_\_\_

**COPAY \$ \_\_\_\_\_**

**VISIT LIMIT \_\_\_\_\_**

**ADDITIONAL BENEFIT NOTES:** \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
**Signature of Policyholder**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Signature of claimant ( if other than policyholder)**

\_\_\_\_\_  
**Relationship to patient**

\_\_\_\_\_  
**LPT Witness**