



PHYSICAL THERAPY • FOR FAMILIES

Insurance Resource Guide

How to verify your benefits, understand the billing process, and plan for the cost of therapy.

Insurance can feel like its own language. This guide is here to help you ask your insurance company the right questions about physical therapy, understand how billing works, and avoid surprises. Please keep in mind that a benefit check is never a guarantee of payment: your plan decides coverage when it processes each claim, and families remain financially responsible for the services they choose to receive.

Three things to know before you start

- 1. Having a physical therapy benefit does not mean every service is covered.** Plans can limit visits, require authorization, or exclude certain diagnoses.
- 2. Ask about both in-network and out-of-network coverage.** Your therapy provider may not be contracted with every plan, and out-of-network benefits can still help.
- 3. Write everything down.** Calls may be recorded. A representative's name and a call reference number make it much easier to resolve a problem later.

How billing works, step by step

Step	What happens
1. Verify your benefits	Use the call checklist in this guide. Your provider may also run its own check.
2. Sign the financial agreement	Many practices keep a card on file and collect an estimate of your share at each visit.
3. Your child is seen	The therapist documents the session and selects the procedure codes that describe it.
4. The claim is submitted	Your provider sends the claim to your insurance plan, usually within a few days.
5. Insurance processes the claim	You receive an Explanation of Benefits (EOB). An EOB is not a bill — it shows what the plan paid and what you owe.
6. Your account is reconciled	If you owe more than the estimate, the difference is charged or billed. If you paid more, you receive a credit or refund.

Questions about a bill or balance? Contact your therapy provider's office directly.



Before you call your insurance

Have this information in front of you. The phone number is on the back of your insurance card.

Patient name		Date of birth	
Insurance plan		Member services phone	
Subscriber (policyholder) name		Subscriber date of birth	
Member ID #		Group #	

You should not need to give your Social Security number to verify benefits.

What to say when you call

*"Hi, I'm calling to verify in-network and out-of-network benefits for my child, [name], for **outpatient physical therapy** in an **office setting**. I'd like to check the following procedure codes."*

Code	Physical Therapy service
97161–97163	PT evaluation
97164	PT re-evaluation
97110	Therapeutic exercise
97112	Neuromuscular re-education
97116	Gait training
97140	Manual therapy
97530	Therapeutic activities
97535	Self-care / home management training
97150	Group therapy

Your provider can tell you which of these codes they use most often.



Verification of benefits call checklist

Fill this in during your call. Use the right-hand columns to record in-network and out-of-network answers separately.

Question	In-network	Out-of-network
The call		
Representative's name, date/time, and call reference number		
Your plan		
Plan effective date		
Calendar-year or plan-year benefits? (When do limits reset?)		
Coverage		
Is outpatient physical therapy covered in an office setting?		
Is therapy by telehealth covered?		
Are habilitative services covered (building skills never developed, such as a developmental delay)?		
Any diagnosis exclusions or pre-existing condition limits? (Ask them to check the Evidence of Coverage.)		
Are therapy benefits managed by a separate company? If so, its name and phone number.		
Your costs		
Does the deductible apply to therapy? Individual / family amount		
How much of the deductible has been met?		
Coinsurance (% plan pays) or copay (\$ per visit)?		
Out-of-pocket maximum, and how much has been met?		
Visit limits		
How many visits are allowed per year, and how many have been used?		
Is the limit shared with PT, OT, and/or speech therapy?		
Do visits applied to the deductible count toward the visit limit?		
Can more visits be approved? How?		
Requirements		
Is a referral or doctor's prescription required?		
Is prior authorization required for the evaluation? For treatment? For which codes?		
Are two different therapies covered on the same day?		
Claims		
Where are claims submitted, and what is the filing deadline?		
Can I request a network gap exception if no in-network provider is available?		



Insurance terms in plain language

Term	What it means
Deductible	The amount you pay each year before your plan starts sharing costs. A plan can have a deductible that does not apply to therapy, so always ask whether it applies.
Coinsurance vs. copay	Coinsurance is a percentage split (for example, the plan pays 70% and you pay 30%). A copay is a flat amount per visit. Therapy is often subject to coinsurance.
Out-of-pocket maximum	The most you pay for covered services in a plan year. After you reach it, the plan pays 100% of covered services. Out-of-network services often have a separate, higher maximum.
Visit limit	The number of therapy visits the plan covers per year. Some plans share one limit across PT, OT, and speech therapy.
Habilitative vs. rehabilitative	Rehabilitative care restores skills that were lost. Habilitative care builds skills a child has not yet developed. Some plans cover only one type.
Prior authorization	Approval the plan requires before services. It is not a guarantee of payment, and it usually covers a set number of visits within set dates.
Network gap exception	Some plans will pay an out-of-network provider at in-network rates when no in-network provider is reasonably available. It usually must be requested before services begin.
Explanation of Benefits (EOB)	The statement your plan sends after processing a claim. It shows the amount billed, what the plan paid, and what you owe. It is not a bill.
Good Faith Estimate	If you are uninsured or choose not to use insurance, you have the right to an estimate of expected charges before care begins.

About additional visits

Plans often approve an initial block of visits and say more may be approved based on medical necessity. In practice, additional visits are frequently approved in small increments, each requiring updated clinical documentation and sometimes a peer-to-peer review with the plan's clinician. This takes time. To keep therapy consistent for your child, plan ahead for the possibility that not every visit will be covered.

If a claim is denied

Denials are common, even when the coverage is there and everything was submitted correctly. Follow-up is what makes the difference.

- **Call your plan** to learn the exact reason. Ask for the denial in writing and a copy of the plan's therapy policy. Note who you spoke with, when, and what was said.
- **Check with your employer's HR or benefits team.** Many employer plans offer a claims advocate who can help.
- **Ask your pediatrician or referring physician** for a letter of medical necessity supporting therapy.
- **File a formal appeal** with member services. Confirm the deadline (often measured from the date of the denial), the mailing address, and the expected response time. Send documents by a trackable method and follow up by phone.



Other ways to help pay for therapy

- **FSA or HSA.** Pre-tax dollars from a Flexible Spending Account or Health Savings Account can generally be used for therapy copays, coinsurance, and private-pay visits.
- **School-based services.** If your child has an IEP or 504 plan, the school may provide therapy related to education. In some cases an Independent Educational Evaluation (IEE) can be completed by an outside provider.
- **Medicaid and state programs.** Many states offer Medicaid waiver or disability programs that cover therapy for qualifying children, sometimes regardless of family income. Your state's Medicaid office can explain options.
- **Supplemental Security Income (SSI).** Children with qualifying disabilities in lower-income households may be eligible. Learn more at ssa.gov.
- **ABLE accounts.** Tax-advantaged savings accounts for people with disabilities that began before a qualifying age. See ablenrc.org.
- **Community and nonprofit support.** Call 2-1-1 or visit 211.org for local assistance, and search the Patient Advocate Foundation (patientadvocate.org) and diagnosis-specific organizations for therapy grants.

Notes and provider information

Additional notes from my call

--

Your therapy provider (ask the front desk if your plan requests these)

Practice name	
Organization NPI	
Tax ID / EIN	
Billing contact and phone	

This guide is general educational information, not legal, tax, or financial advice. Benefit information provided by an insurance representative is not a guarantee of coverage or payment.