# SAMARITAN CHOICE PLANS FITNESS REIMBURSEMENT REQUEST: SHS PHYSICAL THERAPY TRANSFER TO SAMFIT/SAM

**INSTRUCTIONS: SamFit/SAM can submit this form to Samaritan Choice Plans after the following has been completed.**

- SHS Physical Therapist has reviewed your care and has agreed you are a viable candidate for the program.
- SHS Physical Therapist has completed and signed the form requesting care on behalf of the member.
- Member has been given the reimbursement request to review, sign, and approve.
- Member has presented completed form to SamFit or Samaritan Athletic Medicine (SAM) staff.
- SAM or SamFit Health and Fitness Specialist has reviewed, approved, and signed the completed reimbursement request.

**INCOMPLETE FORMS MAY RESULT IN DENIAL OF REIMBURSEMENT FOR ELIGIBLE SERVICES.**

## MEMBER INFORMATION:

| Last name: | First name: | | Middle initial: |
|---|---|---|---|
| Phone #: | Date of birth: | SCP Member ID: | |
| Address: | | | |

If services are provided to you that are not covered by your health plan, you will be responsible for payment in full for those services. Your signature below constitutes agreement to pay for such services. No matter what type of plan you have, it is your responsibility, to know and understand your coverage. Not all services are a covered benefit in all contracts. Contact your insurance company to find out what benefits are covered or excluded under your plan.

**MEMBER SIGNATURE**:______________________________ Date:______________

Print Name:______________________________ Phone: ______________

## PHYSICAL THERAPIST RECOMMENDATIONS

The information provided needs to be legible and complete. Please use *'conditioning'* if there is not a specific area of focus.

**Area of focus** (body part(s): ______________________________

**Physical limitations/restrictions:**______________________________

**Comments:**______________________________

______________________________

______________________________

______________________________

**REQUESTED TREATMENT**: (Choose one)

| | | |
|---|---|---|
| ❑OPTION #1 **Monthly membership** | **Service code S9970** - Monthly health club membership | **# of months:**__________ (3 month maximum) |
| ❑ OPTION #2 **Individual Health & Fitness Specialist instruction by appointment ONLY** | **Service code S9451-** Exercise classes, non-physician provider, per session | |

**Type of service(s):** ❑ Strength training ❑ Flexibility ❑ Cardiovascular ❑ Other: ______________

**# of sessions:** __________ **# of weeks:** __________ **At discretion of the Health and Fitness Specialist** ❑Yes ❑No

**TRANSFERRING PROVIDER SIGNATURE**:______________________________Date: ______________

Print Name:______________________________ Phone: ______________

## SAMFIT/SAM CLAIM REIMBURSEMENT REQUEST

Servicing Location (select one):

❑ **SamFit Lebanon:**
**NPI # 1528304664** TIN#: 93-0396847
35 Mullins Drive, STE. 3, Lebanon, OR 97335
541-451-6990

❑ **SamFit Corvallis**
**NPI # 1063758316** TIN#: 93-0391573
777 NW 9th Street, STE. 310, Corvallis, OR 97330
541-768-5850

❑ **SamFit Albany**
**NPI # 1063758316** TIN#: 93-0391573
380 Hickory Street NW, Albany, OR 97321
541-812-3300

❑ **SAM Facility:**
**NPI # 1013326537** TIN # 93-0391573
845 SW 30TH ST, Corvallis, OR 97331
541-768-7700

**Treatment/Diagnosis: 799.9** Other unknown and unspecified cause
**R69** Illness, unspecified

**Place of Service: 99** Other place of service

| From | Through | POS | Unit | CPT | Charge |
|---|---|---|---|---|---|
| MM/DD/YYYY | MM/DD/YYYY | | # of months or sessions | (opt 1 or opt 2) | Per unit |
| | | 99 | | | $ |
| | | 99 | | | $ |
| | | 99 | | | $ |
| | | 99 | | | $ |
| | | 99 | | | $ |
| | | 99 | | | $ |
| | | 99 | | | $ |
| | | 99 | | | $ |
| **NOTE:** Please do not cross over years, each year period must be entered on a separate line. Enter TOTAL CHARGES. | | | TOTAL CHARGES | | $ |

**PERSONAL TRAINER SIGNATURE:**_______________________ Date:_______________

Name: _______________________ Phone: _______________

**Does this member currently have a SamFit membership paid through Employee Wellness?** ❑Yes ❑No

**NOTE:** This benefit is specific to Samaritan Choice Plans and is not a benefit that can be coordinated between multiple plan coverage. This benefit applies to all members on the Samaritan Choice Plan. Any SamFit classes offered with a required payment are separate from the cost of a gym benefit.

### SUBMIT REQUEST TO:

Samaritan Choice Plans Claims Department
P.O. Box 1310
Corvallis, Or 97330

### INTEROFFICE TO:

Samaritan Choice Plans Claims Department
Avery Square

Payment of this benefit is reliant upon the member's eligibility and by the provisions of this Plan, which is outlined in the Samaritan Choice Plans Member Handbook. This benefit is maintained by the same rights and responsibilities as all other Samaritan Choice Plan benefits. All pre and post service claims timelines will be adhered to as required by law.

# INSTRUCTIONS: HOW TO COMPLETE THIS FORM *(example completed form)*

## PHYSICAL THERAPIST RECOMMENDATIONS

The information provided needs to be legible and complete. Please use *'conditioning'* if there is not a specific area of focus.

**Area of focus** (body part(s): Include the areas in which the member is needing this service and therapy for

**Physical limitations/restrictions:** Recommended service, physical limitations, type of therapy, etc…

**REQUESTED TREATMENT:** (Choose one)

| | | |
|---|---|---|
| ❑ **OPTION #1** Monthly membership | **Service code: S9970 ($30.00/unit)** Monthly health club membership | **# of months:** ________ (3 month maximum) |
| ❑ **OPTION #2** Individual certified trainer instruction by appointment ONLY | **Service code S9451 ($24.00/unit)-** Exercise classes, non-physician provider, per session | |
| **Type of service(s):** ❑ Strength training ❑ Flexibility ❑ Cardiovascular ❑ Other : ________ | | **# of sessions:** ________ **# of weeks:** ________ |

**PHYSICAL THERAPIST SIGNATURE:**____________________ Date:________

Print Name:____________________ Phone: ________

## SAMFIT/SAM CLAIM REIMBURSEMENT REQUEST

Servicing Location (select one):

❑ **SamFit Lebanon:**
**NPI # 1528304664** TIN#: 93-0396847
35 Mullins Drive, STE. 3, Lebanon, OR 97335
541-451-6990

❑ **SamFit Corvallis**
**NPI # 1063758316** TIN#: 93-0391573
777 NW 9th Street, STE. 310, Corvallis, OR 97330
541-768-5850

❑ **SamFit Albany**
**NPI # 1063758316** TIN#: 93-0391573
380 Hickory Street NW, Albany, OR 97321
541-812-3300

❑ **SAM Facility:**
**NPI # 1013326537** TIN # 93-0391573
845 SW 30TH ST, Corvallis, OR 97331
541-768-7700

**Treatment/Diagnosis:** **799.9** Other unknown and unspecified cause; **R69** Illness, unspecified

**Place of Service:** **99** Other place of service

| From | Through | POS | Unit | CPT | Charge |
|---|---|---|---|---|---|
| MM/DD/YYYY | MM/DD/YYYY | | # of months or sessions | (opt 1 or opt 2) | Per unit |
| 01/30/2013 | 04/30/2013 | 99 | 3 | S9970 (per unit) | $ 30.00 |
| 06/15/2013 | 07/15/2013 | 99 | 8 | S9451 (per unit) | $ 24.00 |
| | | 99 | | | |
| **NOTE:** Please do not cross over years, each year period must be entered on a separate line. Enter TOTAL CHARGES. | | | TOTAL CHARGES | | $282.00 |

**PERSONAL TRAINER SIGNATURE:**____________________ Date:________

Name: ____________________ Phone: ________

**Does this member currently have a SamFit membership paid through Employee Wellness?** ❑Yes ❑No