

SUPERBILLS

REIMBURSEMENT GUIDE

How to ask your insurance plan to pay you back for your physical therapy visits.

ROOTED MOTION PHYSICAL THERAPY · CASH-BASED, OUT-OF-NETWORK CARE · A SUPERBILL EVERY MONTH

What is a superbill?

A superbill is a detailed receipt for care you have already paid for. It lists what was done, why, and by whom, using the codes insurance plans read. If your plan includes **out-of-network benefits**, you can send it in and your plan may pay you back part of what you spent.

Rooted Motion does not bill or talk to insurance companies, so this happens between you and your plan. We just give you the paperwork, once a month. Coverage varies from plan to plan, and reimbursement is never guaranteed.

Four steps to getting paid back

1. **Call your plan before you start.** Use the worksheet on page 2 so you know your deductible, what percentage they repay, and what they need from you.
2. **Pay at your visit as usual.** Payment is due at the time of service.
3. **Your superbill arrives at the end of each month.** One document covering every visit that month, in your client portal — you do not need to ask. When care ends you get a final one straight away.
4. **Submit it to your plan.** Attach it to your plan's claim form through their website, by mail or by fax. Keep a copy. Any reimbursement is paid to you, not to us.

Can I use my HSA or FSA card?

Often, yes — and for most people this is worth more than the insurance question, because it does not depend on a plan paying you back. The IRS treats physical therapy as a medical expense when it is **treatment for a specific condition**; care for general fitness or general wellbeing does not qualify, even when a provider has recommended it. That line matters here, because we offer wellness visits alongside treatment. Visits addressing an injury or a condition we are actively managing normally qualify, while visits booked purely to train or maintain may not. Ask us if you are unsure which of yours are which.

Some administrators want a **letter of medical necessity** before releasing funds. We write those on request at no charge. Rules vary between administrators, so confirm with yours — we can document why care was needed, but we cannot tell you what your plan will accept.

At a glance

WHO SENDS IT IN

You do, to your own insurance plan.

WHO GETS PAID BACK

You, directly by your plan.

WHAT WE PROVIDE

One a month, covering that month's visits. A final one when care ends.

WATCH THE DEADLINE

Most plans limit how long after a visit you can file.

What's on your superbill

- ▶ Your name, date of birth, address and phone
- ▶ Each visit date and place of service (12 home, 10 video)
- ▶ Your diagnosis codes (ICD-10), up to four
- ▶ Per visit: CPT code, modifier, diagnosis link, units and charge
- ▶ Practice and therapist details, both NPIs, tax ID and licence
- ▶ Total charged, what you paid, balance due
- ▶ A signed certification that you paid in full

Have Medicare?

This guide is for private insurance plans. Medicare has its own rules for physical therapy, and they are not simply a matter of what you are willing to pay out of pocket, so **please talk with us before you book**.

If your plan says no

- 1 **Ask why, in writing.** The notice has to give a reason. Many out-of-network denials come from something fixable — a missing referral, the wrong place-of-service code, no plan of care on file. Send it to us and we will correct and reissue at no charge.
- 2 **You have at least 180 days to appeal.** That is your internal appeal with the plan, and for care you have already received the plan normally has 30 days to answer it.

- 3 **An outside reviewer may then be available.** Where a plan refuses on medical grounds, Virginia's Bureau of Insurance can send the case to an independent reviewer whose decision binds the plan, within 120 days of the final denial. This route generally does not apply where a plan simply has no out-of-network benefit.

Not sure what to ask? Bring page 2 to your next visit and we will go through it with you.

Call the member services number on the back of your insurance card and say you want to check your **out-of-network outpatient physical therapy benefits**. Type or write the answers here.

PLAN _____ DATE CALLED _____ PHONE _____

REPRESENTATIVE _____ CALL REFERENCE # _____

ASK	ANSWER
1 Do I have out-of-network benefits for outpatient physical therapy?	
2 What is my out-of-network deductible, and how much have I met this year?	
3 Once the deductible is met, what percentage do you pay back?	
4 Do you pay back a percentage of what I paid, or of your own "allowed amount"? What is the allowed amount for the codes on my superbill?	
5 Is there a limit on the number of visits per year?	
6 Do I need a doctor's referral or prescription to be reimbursed?	
7 Do you need pre-authorization before I start?	
8 Will you accept an itemized superbill, or do you need it on a CMS-1500 claim form?	
9 Do you require a GP modifier, or a plan of care signed by a physician?	
10 Are visits in my home covered? (Home visits use place-of-service code 12; video visits use 10.)	
11 How do I submit a claim — online, mail or fax — and which claim form do you need?	
12 What is the deadline for submitting a claim after a visit?	
13 If a claim is denied, how long do I have to appeal, and how do I file one?	

Common physical therapy codes, if your plan asks: evaluation 97161–97163, therapeutic exercise 97110, manual therapy 97140, neuromuscular re-education 97112, therapeutic activities 97530. Your superbill lists the exact codes for your visits.

Claim tracker

DATE SENT	VISIT DATES	AMOUNT	STATUS / REIMBURSED

Need one reissued?

Your superbill comes automatically at the end of each month. For an earlier month, a correction or a reissue, call or text (804) 351-9041 or email info@rootedmotionpt.com. Please don't include health details in texts or email.

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