

INSURANCE VERIFICATION

**USE THIS FORM TO VERIFY COVERAGE FOR CHIROPRACTIC CARE.
PLEASE FILL OUT THIS FORM AND RETURN IT TO OUR OFFICE BY YOUR SECOND VISIT.**

Patient's Name: _____

Subscriber's Name: _____ Relationship to patient: _____

Insurance Company: _____ Ins. Phone #: _____

Date of call: _____ Time of call: _____ Name of Ins. Rep. _____

ASK THESE QUESTIONS

What is my effective Date of Coverage ____/____/____

What is my Benefit Cycle? Calendar Anniversary Date - ____/____/____ to ____/____/____

What is my coverage percentage? _____% Do I also have a fixed amount? \$_____

Does My Policy Cover Chiropractic? Yes No // Do I have a Co-Pay? Yes, amount \$ _____ No

Do I have multiple Co-Pays? (Spinal Manipulation, Evaluation, Physical Medicine) Yes, amount \$ _____ No

Is there a deductible? Yes, amount \$ _____ No // Has my deductible been met? Yes No

If no, how much of my deductible has been met? \$_____

How many chiro.visits per year? _____ // How many have I used this year? _____ as of ____/____/____

Does my plan cover Physical Therapy? Yes No // Per year PT visit limit? _____ Used? _____

Does my plan cover manual therapy? (code 97140) Yes No // Must I Pre-Certify my visits? Yes No

Will a Treatment Plan extend my allowed visits? Yes No // Do I need a referral? Yes No

Does my policy cover x-rays? Yes No If yes, at what % _____

Does it cover Cervical Pillows, Structural Supports? (procedure code E0190) Yes No

Does it cover Orthotics? (code L3020) Yes No // Are there any other limits to my coverage? Yes No

If yes, describe: _____

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- Our desire for you is to be pro-active in your care. We bill your insurance as a courtesy.
 - It is important for you to understand that health and accident insurance is an arrangement between you and your insurance company.
 - Once your insurance has been verified we will accept payment directly from your insurance carrier.
 - In the event your carrier does not pay for your visits, you will be responsible for your bill.
 - Thank you for your cooperation.

Patient Signature: _____ Date: ____/____/____