INSURANCE VERIFICATION FORM

Type of Insurance: ❑ Primary ❑ Secondary ❑ Other

Patient Information:

Name: ____

Date of Birth: ____

Phone: ____

Relationship: ____

Insured's Information:

Name: ____

Date of Birth: ____

Employer: ____

Insurance Information:

Insurance Company: ____ Phone #: ________________________________

Plan Name: ____ Network: ________________________________

Group #: ____ Subscriber ID: ____

(Complete information above before contacting insurance carrier)

Verification:

Date/Time Called: _________________________ Ref. Number: ___________ Rep Full Name: ____________ _____________

Chiropractic Coverage? ❑ Yes ❑ No Begins: ❑ Calendar ❑ Fiscal ❑ Other

Deductible Amount: ______________________

Deductible Amount Met: ______________________

Out of Pocket Max: ______________________

Percentage Covered: ______________________

Co-Pay Amounts: ______________________

Effective Date: ______________________

Secondary Insurance Automatic Crossover: ❑ Yes ❑No 4th Quarter Carryover? ❑ Yes ❑ No Amount: _________

Are services covered if performed by a chiropractic?				**Additional services that may be provided:**			
	Covered Service	Subject to Deductible	After Deductible Pays		Covered Service	Subject to Deductible	After Deductible Pays
Maintenance Care:				Physical Therapy:*			
Spinal Adjustment:				**If physical therapy services are performed by a licensed physical therapist, a separate Insurance Verification Form should be completed.*			
Extra Spinal Adjust.:				Massage:			
Examination:				Acupuncture:			
Re-Examination:				Orthotics:			
X-Ray:							
Modalities: *(List specific modalities and verify how many are allowed per visit.)*							

Limitations:

Does Occupational Therapy or Physical Therapy count towards Chiropractic visit max? ❑ Yes ❑ No

How many Visits: Per Year:_________ Per Diagnosis:________ Max Allowed Per Year: ____________________

Referral or Pre-Authorization Required? ❑ Yes ❑ No Pre-existing Clause? ❑ Yes ❑ No