INSURANCE VERIFICATION FORM

Type of Service: ❑ Chiropractic ❑ Physical Therapy **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 Chiropractor 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

Information recorded on this verification form is a quote of your benefits as outlined to us by your insurance company. This information is provided to you as a courtesy and is NOT a guarantee of payment OR coverage. At your request, we will bill your services to your insurance, however, you are ultimately responsible for your bill.

_____ *(Patient)* _____ *(Date)*