

Insurance Verification Form

Type of Insurance: Primary Secondary Other

Patient Information

Name: _____

DOB: _____

Contact #: _____

Relationship: _____

Insured's Information

Name: _____

DOB: _____

Employer: _____

Insurance Information

Insurance Company: _____ Phone #: _____

Plan Name: _____ Network: _____ Group #: _____

Subscriber ID: _____ Provider #: _____

(Complete all information above before calling insurance carrier)

Verification

Chiropractic Coverage? Yes No

Date Called: _____ Time Called: _____ Ref #: _____

Spoke To: _____ (First and Last Name) Begins: Calendar Fiscal Other

Deductible Amount: \$ _____ Deductible Amount Met: \$ _____ Out of Pocket Max: \$ _____

Percentage Covered: _____ % Co-Pay Amount \$ _____ Effective Date: _____

Secondary Insurance Automatic Crossover: Yes No

4th Quarter Carryover? Yes No Amount: \$ _____

Are services covered if performed by a chiropractor?

	Covered Service	Subject To Deductible	After Deductible Pays
Maintenance Care:			
Spinal Adjustment:			
Extra Spinal Adjustment:			
Examination:			
X-Ray:			
Physical Therapy:			
Massage:			
Acupuncture:			
Orthotics:			
Other:			
Other:			

Limitations

Does Occupational or Physical Therapy count toward 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