

INSURANCE VERIFICATION FORM

Our policy is set up to utilize direct payment from insurance companies. This is done as a service to our patients and there is no charge for this service. However, it is important that you understand that health and accident insurance policies are an arrangement between you and your insurance company. You are responsible for all service charges incurred in our office.

Patients Name: _____ Date: ____/____/____

Please fill out this form and return it to our office at your next visit. Here is what you do to verify coverage for chiropractic care.

Date you called insurance company ____/____/____

Name of the person you spoke to: _____

Phone number of insurance company: () _____ - _____

Policy number: _____

Individual Policy? Yes No Group Policy? Yes No

Name policy is under: _____

1. Ask the following questions:

- a. Does my policy cover chiropractic: yes no
If yes, are there any limits to my coverage? yes no
What are those limits? _____
Is there a limit to the number of visits allowable? _____
Do I need a referral? yes no
Do I need precertification? yes no
- b. Do you cover cervical pillows, supports? yes no
Do you cover nutritional supplements? yes no
- c. Does my policy cover x-rays done in the chiropractic office? yes no
If yes, at what percentage? _____
- d. Does my policy cover orthotics (in a chiropractic office)? yes no

2. What is my deductible? _____ Is that annual? _____
Has it been paid? yes no If yes, how much? _____
Is there a carry over? yes no Is there a family deductible? yes no

What is my co-payment or co-insurance? _____

What is the effective date of my policy? _____

Can benefits be assigned to my chiropractors office? yes no

What is the address where claims are sent?

To whose attention are claims sent? _____

Please circle the one that applies to your case: Major Medical/Personal Injury/Worker's Comp
If you have any questions or problems please direct them to the office staff.

Date: ____/____/____ Patient Signature: _____