INSURANCE VERIFICATION FORM

Patient's Name: _____

Date of Birth: _____ Today's Date: _____

Please have the following information when calling your insurance company:

1. Insurance company's phone number (on the back of your card): _____

2. Policy holders name (if different from patient): _____

Please obtain and verify the following information.
We/they cannot process your claim without this information. Thank you.

1. Ask for the name of the person giving you this information: _____
2. Ask if you have chiropractic coverage for ***"out of network"*** providers.
   If yes, please continue to verify type and amount of coverage.

A. What is the yearly deductible? Per Person _____ Per Family _____

B. How much of the deductible has been met this year: _____

C. What is the co-pay: _____

D. Is there a limit to the number of visits or $ amount? _____ If yes, how many visits are allowed and/or what is the $ limit? _____

E. Are services limited by "Medical Necessity"? _____

F. Do they cover Wellness or Maintenance Care? _____

G. What is the effective date of the policy? _____

H. Policy holder's employer: _____ ID# _____

I. Name and address of the insurance office where the claims are sent:

_____

_____

_____

Thank you for obtaining and verifying this information with your ins. company.

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