

INSURANCE COVERAGE VERIFICATION

Date: _____

Insured Name: _____ D.O.B: _____ Telephone: () _____

Address/City/State/Zip: _____

Patient: _____ D.O.B: _____ Telephone: () _____

Address/City/State/Zip: _____

Relationship to Insured: Self Spouse Child Other _____

Insurance type: Government/Public Sectors (Medicare, Medicaid, Federal, State, City, etc.): _____

Non-Govt. Org./Private Sectors (Group Ins., Self-Funded Plans, Private Schools): _____

Self Insurance/Consumer Directed (MSA, HSA, Personal Insurance): _____

Other (Personal Injury, Worker's Comp, etc.): _____

Insurance Company: _____ Telephone: () _____

Address/City/State/Zip: _____

Policy #: _____ Group #: _____ ID #: _____

Injury/Accident Date: _____ Time: _____ AM PM

Insured's Employer: _____ Telephone: () _____

Address/City/State/Zip: _____

FOR OFFICE USE

Insurance Contact Name: _____ Employee Administrator Other

Is there coverage for chiropractic care? YES NO

Fiduciary of ERISA plan: _____ Telephone: () _____

HMO PPO Other _____

Is it a panel provider? YES NO If no, does it have an out of panel provision? YES NO

Is pre-authorization required? YES NO If yes, # _____

Deductible: \$_____/Individual \$_____/Family Has deductible been met? YES NO

Coverage after deductible In network ____/____% Out of network ____/____%

When is next deductible due? _____

Is there a maximum yearly benefit? _____ Is there a maximum visit limit? _____

Are diagnostics applied to deductible? YES NO

Visit limits per year _____ Have they been met? YES NO

Does this policy cover: E/M CMT Physical Medicine Procedures Nutritional Supplement

Orthopedic Supports Other _____

Does your company assign benefits to the doctor? YES NO

Is there an accident rider? YES NO If yes, how much? \$_____

Is a fee schedule available? YES NO

Exclusions/Limits: Diagnoses _____

Procedures _____

Claims: Are CMS-1500 forms accepted? YES NO Mail claims to attn: _____

Where are claims to be submitted (other than insurance co.)? _____

Fax claims to: _____ Electronic claims to: _____

Are special reports or forms needed? YES NO If yes, when? _____

Verification Date: _____ By: _____

