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Insurance Verification Form

We encourage all patients to verify their insurance benefits prior to their first visit to fully understand your policy and treatment coverage. Please call the customer service number on the back of your insurance card.

Name: _____ DOB: ____/____/____

Policy Holder's Name: _____ DOB: ____/____/____

Primary Insurance: _____ ID#: _____

Secondary Insurance: _____ ID#: _____

Please ask the following questions:

Effective date of the policy: ____/____/____

Is my provider covered/part of my network? Yes No-Ask next question.
 Is there an out of network benefit? Yes No

Details: _____

Is there a deductible for my policy? Yes-Ask next question No

Amount of deductible: _____ Amount of deductible met: _____

Is the deductible based on a fiscal or a calendar year? Fiscal Calendar

If based on a fiscal year: _____ to _____

Does the deductible apply to chiropractic benefits? Yes No

How many chiropractic treatments may I receive? _____ How many have been used? _____

How many adjunctive therapy treatments may I receive? _____ How many have been used? _____

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

Are these commonly recommended treatments covered with my plan?

Procedure	Procedure Code	<input type="checkbox"/> Yes	<input type="checkbox"/> No
New Patient Examination	99201-99203	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Established Patient Examination	99211-99213	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Spinal Manipulation	98940-98941	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Extremity Manipulation	98943	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Mechanical Traction	97012	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Therapeutic Exercise	97110	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Manual Therapy	97140	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Is durable medical equipment covered (L3000)? Yes No Details: _____

Is advanced imaging covered (MRI)? Yes No Details: _____

Is pre-certification required for advanced imaging? Yes No

Pre-certification point of contact: Phone: _____

Is pre-certification needed for any other treatment procedures? Yes No On what services: _____

Pre-certification point of contact: Phone: _____

Reference # for your call: _____ Date of call: ____/____/____

Please fax or bring completed form with you for your first scheduled appointment.