



Insurance Verification

Personal Info

Patient name: _____ Date I called insurance company: _____

My Contract # is : _____ My Group # is: _____

I spoke to: _____ Is there a reference #? _____

How does my Policy year run? (ie jan-Dec, July- Jun) : _____

Do I need a referral from a primary care physician? YES or NO

Do I have a **Deductible**? YES or No How much is it? _____ How much has been met? _____

Is there a maximum amount that your insurance will contribute to chiropractic care?

YES or NO How much? _____

Office Visit/ Exams (Exam- code 99203)

Does insurance cover Office visits- exams? YES or NO How often? _____

How much do I pay while still paying off my deductible? _____

What is my Copay after my deductible is met? _____

Adjustments (Manipulation – code 98941)

How many Manipulations (adjustments) does insurance contribute to? _____

Have I used visits at another chiropractor? YES or No If so, how many were used? _____

How much do I pay while still paying off my deductible? _____

What is my Copay after my deductible is met? _____

I understand that this information which was provided by my insurance company, may or may not be accurate, is **NOT** a guarantee of payment, and may change at **ANYTIME**.

I agree to be responsible for payment of all services rendered (on my or my dependents behalf) **DENIED or NOT** covered by my insurance company.

Pateint Name _____

Patient Signature _____

Date _____