INSURANCE VERIFICATION

New:_____ Reactivated:_____ Change in Ins:____ Primary Cov:_____ Secondary Cov:_____

Patient's ID#:_____

Patient's Name:_____ Relationship to Insured:_____

Insured's Name:_____ Patient's DOB:_____

Insured's Employer:_____ Insured's DOB:_____

Insurance Carrier/Plan:_____

REF/SEQ#_____

Claims Billing Address:_____

_____

Carrier Telephone#: _____

Staff Member Initials:_____ Date Confirmed:_____

Contact Name:_____ Filing timeframe:_____

Effective Date of Cov:_____ ID#:_____

Group Name: _____ Group: _____

Calendar Year:_____

Co-Pay: $_____ OR Out of pocket _____ Met_____ Remaining_____

Deductible: $_____ Remaining This Year: $_____ Co-Ins After Deductible:_____%

Number of Visits Covered Annually:_____

PCP Referral Needed? Yes / No Auth#: _____

Treatment Plan? Yes / No When?_____

X-Rays Covered? Yes / No At____ % Are X-Rays subject to the deductible? Yes / No

Does this Patient have out-of-network benefits for chiropractic care? Yes / No

Co-Pay: $_____ OR Out of pocket_____ Met_____ Remaining_____

Deductible: $_____ Remaining This Year: $_____ Co-Ins After Deductible:_____%

Number of Visits Covered Annually:_____

PCP Referral Needed? Yes / No Auth#: _____

Treatment Plan? Yes / No When?_____

X-Rays Covered? Yes / No At____ % Are X-Rays subject to the deductible? Yes / No