

# Insurance Verification Form

Type of Insurance:    Primary  Secondary  Other

**Patient Information**

Name: \_\_\_\_\_  
 \_\_\_\_\_  
 DOB: \_\_\_\_\_  
 \_\_\_\_\_  
 Contact #: \_\_\_\_\_  
 \_\_\_\_\_  
 Relationship: \_\_\_\_\_  
 \_\_\_\_\_

**Insured's Information**

Name: \_\_\_\_\_  
 \_\_\_\_\_  
 DOB: \_\_\_\_\_  
 \_\_\_\_\_  
 Employer: \_\_\_\_\_  
 \_\_\_\_\_

**Insurance Information**

Insurance Company: \_\_\_\_\_ Phone #: \_\_\_\_\_  
 Plan Name: \_\_\_\_\_ Network: \_\_\_\_\_ Group #: \_\_\_\_\_  
 Subscriber ID: \_\_\_\_\_ Provider #: \_\_\_\_\_

**(Complete all information above before calling insurance carrier)**

**Verification**

Chiropractic Coverage? Yes  No   
 Date Called: \_\_\_\_\_ Time Called: \_\_\_\_\_ Ref #: \_\_\_\_\_  
 Spoke To: \_\_\_\_\_ (First and Last Name) Begins: Calendar  Fiscal  Other   
 Deductible Amount: \$ \_\_\_\_\_ Deductible Amount Met: \$ \_\_\_\_\_ Out of Pocket Max: \$ \_\_\_\_\_  
 Percentage Covered: \_\_\_\_\_ % Effective Date: \_\_\_\_\_  
 Secondary Insurance Automatic Crossover: Yes  No   
 4<sup>th</sup> Quarter Carryover? Yes  No  Amount: \$ \_\_\_\_\_

**Are services covered if performed by a chiropractor?**

	Covered Service	Subject To Deductible	After Deductible Pays
Maintenance Care:			
Spinal Adjustment:			
Extra Spinal Adjustment:			
Examination:			
X-Ray:			
Physical Therapy:			
Massage:			
Acupuncture:			
Orthotics:			
Other:			
Other:			

**Limitations**

Does Occupational or Physical Therapy count toward Chiropractic visit max? Yes  No   
 How Many Visits:            Per Year \_\_\_\_\_            Per Diagnosis \_\_\_\_\_  
 Max Allowed Per Year: \$ \_\_\_\_\_  
 Referral or Pre-Authorization Required? Yes  No     Pre-existing Clause? Yes  No