INSURANCE VERIFICATION _____ DATE:_____TIME:_____

NAME OF CARRIER_____ PHONE_____

NAME OF PATIENT _____ DOB _____

NAME OF INSURED _____ DOB_____

PATIENT RELATIONSHIP TO INSURED: SELF ___ SPOUSE ___ CHILD ___

PATIENT ID # _____ GROUP # _____

NAME OF CONTACT _____ REF # _____IN-NETWORK Y ___ N ___

1. Is policy in effect? Y___ N ___ Effective date of policy? _____
2. Is policy written for a calendar or fiscal year? Cal ___ Fy ___ FY Dates _____ to_____
3. Does this policy cover Chiropractic Manipulations (98940, 98941, 98942)? Y___ N ___
4. Does the patient have a deductible to meet? Y___ N ___ **(if NO, skip to #8)**
5. If yes, is the deductible an Individual or Family deduct? Ind___ Fam___
6. If yes, how much is the deductible? $_____Ind $_____Fam
7. How much of the deductible has been met? $_____ Ind $_____ Fam
8. Does the patient have a coinsurance? Y___ N___ **(if NO, skip to #10)**
9. If yes what is the patient's coinsurance? _____%
10. Does the patient have a co-pay (fixed $ amount per visit)? Y___ N ___ (**if NO, skip to #13**)
11. If yes, what is the co-pay? $_____
12. Is this copay for Exams/Office visits only or ALL visits/treatments? _____
13. What is the patient's Out-of-pocket max? $_____ Met? _____
14. Are there any limitations on Chiropractic services? Y___ N ___
15. If YES,
    a. Number of Visits _____ Number of Visits used _____
    b. $ Amount per cal/FY $_____ Amount used $_____
    c. $ Amount per day (Daily capitation/global fee) $_____
    d. Procedures per day _____
16. CPT CODES: **DO YOU COVER THESE CPT CODES**? 98943 ___ 97012 ___ 97140___ 97124___ 97014/G0283 _____ 97110___97112 ___97035___ 97036 ___ 97530 ___ 95907____ XRAY___ EXAM ____ /how many ORTHOTICS-L3020/L3030 ____ L0631 ___ Nutri Coun-97802 ___ E0730____ S8948_____ S9090_____
17. Are there different benefits for: DME/Orthotics? Y___ N___ X-ray? Y___ N____ (If yes to any item, describe benefits below in space provided, ask whether preauth is necessary for DME/Orthotics)
18. Is preauthorization required for any services? Y ___ N ___
19. If yes, provide details of preauthorization requirements

_____

MISC/ADDITIONAL INFO ON BENEFITS: _____

_____

ELECTRONIC PAYER ID and/or MAILING ADDRESS for claims:

_____

New Patient ___ Established ___ New Policy ___ Update ___ Verified by _____