INSURANCE COVERAGE/BENEFITS VERIFICATION

Patient Name_____________________________ Patient's SS#:_________________________

Insured's Name_____________________ Insured's SS#_____________________________

Relationship to Patient: ( ) Same ( ) Spouse ( ) Child

Insurance Co._________________________________Phone#_________________________

Mail Claims to: ____

Effective Date: ___________________________ Group#: ____________________________

Is either a claim form ( ), initial report ( ), or treatment note ( ) required with billing?

CHIRO/PT: Covered? ( )Yes ( ) No Benefits payable at ________%

Deductible _______ ( ) Individual ( ) Family Amount met___________ Copay ___________

X-Rays ______% Are these benefits combined with other Dr. visits? ( ) Y ( ) N

With whom: ____

Durable Medical Equipment (i.e. Tens unit, EMS units):Covered ( ) Y ( ) N

M.D. Referral Needed: ( )Yes ( ) No

Is Pre-authorization required ? ( )Yes ( )No Phone #: ___________________________

Percentage Covered: ________%

(If Dr. is a provider for above Insurance plan) "Ask is DME reimbursable if the Dr. bills for the equipment, (i.e. TENS/EMS unit)".

Does Patient Have Out Of Network Benefits? ( )Yes ( ) No - If Yes, Ded. Amount: $________

Special Instructions: ____

Insurance Company Contact: ____
Name Date

Verified by: ____
Name Date