VERIFICATION OF INSURANCE BENEFITS

IF GROUP INSURANCE: Is there coverage for Chiropractic Care? YES ☐ NO ☐ DATE ___/___/___

Plan Administered by _____ Is Doctor **In Network** ☐ **Out of Network** ☐

Pre-Authorization Required? ? YES ☐ NO ☐

IN NETWORK BENEFITS

Amount of Deductible:$_____/Individual $_____/Family

Deductible met? YES ☐ NO ☐ $_____ Remaining

Deductible **Calendar** ☐ or **Fiscal** ☐ Renewal Date ___/___/___

Max. Yearly Benefit ? $ _____ Co-pay $_____ % Coverage ____

Max. Yearly Visit Limit? _____

Orthotics Coverage (CPT Code: L3030)? YES ☐ NO ☐ $_____

OUT OF NETWORK BENEFITS

Amount of Deductible:$_____/Individual $_____/Family

Deductible met? YES ☐ NO ☐ $_____ Remaining

Deductible **Calendar**☐ or **Fiscal** ☐ Renewal Date___/___/___

Max. Yearly Benefit ? $ _____ Co-pay $_____ % Coverage ____

Max. Yearly Visit Limit? _____

Orthotics Coverage (CPT Code: L3030)? YES ☐ NO ☐ $_____

Exclusions/Limitations: _____

Exclusions/Limitations: _____

Notes: _____

Spoke to Whom?_____

Direct Telephone: _____

Mail Claims to: _____

Address: _____

City _____ State _____ Zip _____

IF AUTO ACCIDENT

Who was found at fault / ticketed **Patient** ☐ **Other Driver** ☐

Insured Auto Insurance Carrier._____ Address _____

City _____ State _____ ZIP Code _____ Phone#(_____)_____

POLICY NUMBER _____ CLAIM NUMBER _____

Adjuster for the Claim? _____ Coverage Verified?_____

Deductible Amount? $_____ Spoke to Whom?_____

Does your auto insurance coverage have **Medical Payments** Coverage? YES ☐ NO ☐

If yes, Auto Insurance Carrier._____ Address _____

City _____ State _____ ZIP Code _____ Phone#(_____)_____

POLICY NUMBER _____ CLAIM NUMBER _____

Adjuster for the Claim? _____ Coverage Verified?_____

Deductible Amount? $_____ Spoke to Whom?_____

ATTORNEY'S NAME _____ PHONE#(_____)_____

IF WORKER'S COMPENSATION:

Employer's Name_____ Employer's #(_____)_____

Employer's Address:_____ Is patient Currently Employed at Same? _____

Has the injury been reported? YES ☐ NO ☐ Has care been authorized? ? YES ☐ NO ☐ By whom? _____

Employer's Insurance Carrier._____ Address _____

City _____State _____ ZIP Code _____ Phone#(_____)_____

POLICY NUMBER _____ GROUP NUMBER _____