VERIFICATION OF INSURANCE BENEFITS

Name of Patient _____ Date of Birth _____

Name of Insured _____ Relationship _____

Insured's ID # _____ Group Number _____

Name of Insurance Company _____ Phone Number (_____)_____

Claim Address of Insurance Company _____

QUESTIONS TO ASK

Date and Time of call: _____ Who am I speaking with? _____

Is this plan based on : Calendar / Fiscal / Plan Year (From _____ To _____)

Does this policy cover **Chiropractic?** Yes / No MD Referral / Prescription required? Yes / No

How much is the deductible? _____ Amount Remaining _____ Co-pay amount? _____

What is the percentage covered for: Exam _____ X-rays _____ Office Visits _____

# of visits allowed per year? _____ # Remaining _____ Maximum dollar amount per visit or year? _____

Are braces, supports, pillows covered? Yes / No _____

Does this policy cover **Massage Therapy?** Yes / No DC / MD Referral / Prescription required? Yes / No

How much is the deductible? _____ Amount Remaining _____ Co-pay amount? _____

What percentage does major-medical pay? _____

# of visits allowed per year? _____ # Remaining _____

Maximum dollar amount allowed per visit or year? _____

Does this policy cover **Acupuncture?** Yes / No DC / MD Referral / Prescription required? Yes / No

How much is the deductible? _____ Amount Remaining _____ Co-pay amount? _____

What percentage does major-medical pay? _____

# of visits allowed per year? _____ # Remaining _____

Maximum dollar amount allowed per visit or year? _____

I understand that this is a question of benefits and NOT a guarantee of payment, and the agreement is between the insurance carrier and myself. Any denial of payment becomes my patient responsibility.

Patient Signature: _____ Date: _____