

# Insurance Verification Form

Internal Use Only

Please type or print legibly

<b>Patient</b>	Last		First		Middle Initial
	<input type="checkbox"/> Male	<input type="checkbox"/> Female	Date of Birth - month / day / year		S.S.#
<b>Mailing Address</b>	Street Address				
	City		State		Zip

<b>Policy Holder (Insured)</b>	Last		First		Middle Initial
	Home Phone		Cell Phone		Work Phone
	Employer				S.S.#

<b>Insurance Company</b>	Name				
<b>Mailing Address</b>	Street Address				
	City		State		Zip
<b>Phone</b>	Main		Claims		Claims Fax
<b>Policy</b>	<input type="checkbox"/> Group	<input type="checkbox"/> Private	Group #		Employee / Policy #
<b>Insurance Representative Contacted</b>	Name				
	Phone		Contact date - month / day / year		Contact time - hh:mm

Questions to ask the insurance representative:

Does my policy cover chiropractic care? <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Only with a doctor's referral
What is the effective date of my policy? _____ (month / day / year)
What are the deductible amounts? Individual \$ _____ Family \$ _____
Is the deductible <input type="checkbox"/> per calendar year? <input type="checkbox"/> per condition?
Is there an end-of-the-year deductible carry over? <input type="checkbox"/> Y <input type="checkbox"/> N
Are there any 'pre-existing condition' clauses? <input type="checkbox"/> Y <input type="checkbox"/> N
Policy Coverage: Exams _____ % X-rays _____ % Adjustments/Treatments _____ % Supports/Orthotics _____ %
Any Limitations? Visits # _____ Per visit \$ _____ Per year \$ _____ Maximum Payout \$ _____

<b>Completed by</b>	Last	First	Middle Initial
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