PATIENT'S GUIDELINES TO FOLLOW FOR SELF INSURANCE VERIFICATION

THIS IS _____, I'M CALLING TO VERIFY MY COVERAGE FOR CHIROPRACTIC CARE.

INSURED S.S. # _____ GROUP # _____ EMPLOYER _____
INSURED: _____ PATIENT: _____ EFF. DATE: _____
DX/COMPLAINT: _____

INS. CO. _____ CLAIM MAILING ADDRESS: _____
PHONE # _____ SPOKE WITH: _____ DATE CALLED: _____

CHIROPRACTIC BENEFITS

Do I have a yearly deductible? _____ individual $ _____ Family $ _____
How much has been met? _____
What % is covered _____ up to $ _____ out of my pocket before it goes to 100%

DO I HAVE ANY SPECIAL LIMITS ON CHIROPRACTIC CARE?

Is there a specific number allowed a year? _____
Do I need them to be authorized? _____
Is there a maximum amount for chiropractic per year? _____
Is there a maximum amount per visit or is it at my percentage? _____

DOES MY POLICY COVER THERAPY?

Is there a number of visits allowed? _____
Do I need authorization for therapy? _____
Is it paid at my percentage or is it included in a maximum amount per visit? _____

DOES MY POLICY COVER X-RAY?

Are x-rays covered at the percentage or a maximum amount per year?_____

DO I HAVE COVERAGE FOR REHAB? (PHYSICAL TREATMENT)

Is (Pre-authorization required) **YES / NO**
At what percentage is it covered? _____
Is there a certain number the policy covers? _____

DOES MY POLICY COVER ANY SUPPLIES LISTED BELOW?

Pillows _____ Back supports _____ Vitamins _____ Foot orthotics _____

DOES THE POLICY HAVE AN ACCIDENT CLAUSE YES / NO

Is is covered at 100% for a certain amount then at a percentage? _____

PLEASE RETURN COMPLETED FORM TO OUR OFFICE.