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INSURANCE VERIFICATION FORM

Call insurance company and follow prompts to insurance benefits and try to get to an actual person (insurance benefit representative).

Patient's Name_____ DOB_____

Policy Holder_____ DOB_____

Insurance Co. _____ Phone #_____

I.D. #_____Group #_____ Effective Date_____

1. Does the policy include benefits for chiropractic care? _____
2. Do they have **In** and/or **Out** of network chiropractic benefits? _____
3. Is the doctor **In** network? _____ Is the doctor **Out** of network?_____
4. Does patient need a referral? _____ Does patient need a treatment plan?_____
5. How much is their deductible?_____ Calendar or Contract year?_____

   How much has been met for this year? _____Ind._____Fam._____
6. Percentage **Out** of network _____ Co-pay for **In** network_____
7. Is there a maximum # of visits allowed per calendar year?_____
8. Is there a maximum dollar amount per calendar year? _____
9. Is there a maximum amount per visit? _____ How Much?_____
10. How many modalities are allowed per visit? _____
11. What is the amount of x-ray or lab coverage? _____
12. Will they honor the doctor's assignment of benefits? _____
13. Address to submit claim forms to if different from insurance card?

    _____
14. Do they accept standard HICFA form or are special forms required?_____
15. Can HICFA forms be Faxed?_____ What is the fax # ?_____
16. Name of person spoken to at insurance Co._____
17. Sign and Date_____