

# INSURANCE VERIFICATION FORM

Practice Member's Name (printed):

\_\_\_\_\_

Date of Birth: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Please have the following information when calling your insurance company:

1. Insurance company's phone number (on the back of your card): \_\_\_\_\_
2. Policy holders name (if different from practice member's): \_\_\_\_\_
  - A. Policy holders Date of Birth: \_\_\_\_\_
  - B. Policy holder's Address: \_\_\_\_\_ Phone Number: \_\_\_\_\_
  - C. Policy holder's employer: \_\_\_\_\_ ID# \_\_\_\_\_  
Group # (if applicable to your policy): \_\_\_\_\_

Please obtain and verify the following information. We/they cannot process your claim without this information. Thank you.

1. Ask for the name of the person giving you this information: \_\_\_\_\_
2. Ask what your "out of network" benefits are: \_\_\_\_\_
3. Ask what your "in network" benefits are including:
  - A. Do you need a referral? \_\_\_\_\_ If yes, from whom? \_\_\_\_\_
  - B. What is the yearly deductible: Per Person: \_\_\_\_\_ Per Family: \_\_\_\_\_
  - C. How much of the deductible has been met this year: \_\_\_\_\_
  - D. What is the co-pay: \_\_\_\_\_
  - E. Is there a limit to the number of visits or \$ amount?: \_\_\_\_\_
    - i. If yes, how many visits are allowed and/or what is the \$ limit?: \_\_\_\_\_
  - F. Are services limited by "Medical Necessity"? \_\_\_\_\_
  - G. Do they cover Wellness or Maintenance Care? \_\_\_\_\_
  - H. What is the effective date of the policy: \_\_\_\_\_
4. Name and address of the insurance office where the claims are sent:  
\_\_\_\_\_  
\_\_\_\_\_

Thank you for obtaining and verifying this information with your insurance company. We expect they will reimburse you or your account as noted above.

# DENETTE FAMILY CHIROPRACTIC INSURANCE INFORMATION

Insurance is a contract between the insured (practice member) and the insurance company. The following information will help you to understand how insurance can be utilized in our office and the details regarding your participation in the process.

PLEASE READ ALL THE FOLLOWING INFORMATION TO CLARIFY INSURANCE PROCEDURES.

Insurance companies, such as HMO's, PPO's and others, create their own guidelines and are not required to cover chiropractic services. If chiropractic services **are covered**, the amount and type of reimbursement varies according to the policy that has been purchased by you or your employer. (See reverse for details)

If you have determined that your insurance will cover your care in our office, we will work with you to receive your entitled benefits. You can utilize the "Insurance Verification Form" (on the back of this form) when you inquire about your coverage.

Please understand that you are responsible to pay for all services not covered by your insurance company including deductibles, co-payments and any other balances not reimbursed by the insurer.

NOTE: You must verify the type and amount of coverage before we can submit claims on your behalf. On the reverse side of this form is an "**Insurance Verification Form**" that will assist you in obtaining all the vital information needed for us to accept and submit bills to your insurance. **Until we receive this information, your account will be on a cash basis.**

I HAVE READ, UNDERSTAND AND AGREE TO COMPLETE ALL FORMS NECESSARY TO ALLOW DENETTE FAMILY CHIROPRACTIC TO ASSIST ME WITH INSURANCE REIMBURSEMENT. I UNDERSTAND THAT I AM PERSONALLY RESPONSIBLE FOR ALL SERVICES RECEIVED SHOULD MY INSURANCE FAIL TO REMIT PAYMENT.

Practice Member's Name Printed: \_\_\_\_\_

Practice Member's Signature: \_\_\_\_\_ Date: \_\_\_\_\_