Insurance Verification Form

Date: Rep:

Patient Information Eff Date

Name DOB

ID# Group#

Relationship to Insured: Self Spouse Child Other

Insured (if Patient is not the insured)

Name DOB

Calender Fiscal

Claim Submittal:

Pre-authorization required? Yes No If yes, #

IN Deductible $ Met? Yes No Amount Applied

OUT Deductible $ Met? Yes No Amount Applied

Is Ded Common? Yes No % Coverage?

Is there a fourth quarter carry over? Yes No

ChiroVisit Max# $ PT Visit Max# $

Chiro and PT Combined? Yes No

Is PT billed by a DC considered under Chiro or PT benefits?

ACU covered? Yes No Max# $

Limit units billed per visit?

How many Office visits (exams) per year?

Pre-Existing condition policy:

REF Number