Chiropractic Whole Health

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Chiropractic Benefits Insurance Verification Form

PLEASE CALL YOUR INSURANCE COMPANY TO VERIFY YOUR COVERAGE

Patient Name:____________________________________Date of Birth:________________

Primary Insurance Company:____

Policy Number:____________________________________Group number:______________

Primary Insurance phone number:___________________ Effective date:______________

Deductible $___________ Amount met to date $__________ Does the deductible apply to chiropractic? Yes___ No___

Out of Pocket Max$________ How Much OOP Met to date $_____

Co-pay Amount$___________ Co-insurance Amount percentage?________

Does patient have to pay co-pay AND coinsurance for Chiropractic? Yes___ No____

Are there multiple copays for exams, manipulation and modalities? Yes___ No____

Is a referral from primary doctor needed for chiropractic? Yes___ No____

Is policy based on calendar year or contract year? Calendar _____ Contract/Plan year______

If contract year, what are the dates: ____________

Is there a limit on number of visits per year: _____________ OR Dollar amount per year: _______________

Does this plan require authorization for Chiropractic Care? Yes No

If yes, who is authorization through? __________________

Is pre authorization needed for MRI? Yes No If yes, who is authorization through? ____________________

Is there coverage for Durable Medical Equipment? Yes____ No___

If yes, what is covered (orthotics, tens unit, back braces, traction units)? _____________

Is there a limit on modalities billed per day? Yes____ No____ If yes, how many?_______

Who manages the claims? ____

Is 97110 a billable code? Yes ___ No___

Is 97124 a billable code? Yes___ No___ If Yes, is it covered by a Licensed Massage Therapist?_____________

Date of call____________ Rep's Name_________ Call Reference number:________________________________