

INSURANCE VERIFICATION

Patient Name: _____ SSN: ____ / ____ / ____ DOB: ____ / ____ / ____

Policy Holder Information

Type of insurance? (circle one): Primary Secondary

First Name: _____ Middle Initial: _____ Last Name: _____

Address: _____ City: _____

State: ____ Zip: _____ Home #: (____) _____

Social Security #: ____ / ____ / ____ DOB: ____ / ____ / ____

Employer Information: _____ Work #: (____) _____

Insurance Carrier: _____ Member Services / Customer Service #: (____) _____

Policy Holder's Name (as it appears on card): _____

Policy # / ID #: _____ Group #: _____ Effective Date: ____ / ____ / ____

For office use only. Please do not write below this line.)

Insurance Rep Name: _____

Self-Funded? Yes No **Fully-Funded?** Yes No **ASO?** Yes No **ERISA?** Yes No **Individual Policy?** Yes No
(If self-funded, then you must circle **no** for fully-funded)

Do the visits need to be on consecutive days? Yes No

Is there a maximum number of modalities that can be billed in a day? Yes No (If yes, what is the amount? _____)

Will PT be covered if there is no Physical Therapist on staff in the office? Yes No

Benefit Cycle:

__ Calendar (Jan - Dec) __ Anniversary (June - May) Cycle Date: _____ EFT Date: ____ / ____ / ____

Coverage _____ % Co-pay? \$ _____

Ind. Deductible: \$ _____ Met: \$ _____ Family Deductible: \$ _____ Met: \$ _____ Carryover Apply? Yes No

Chiropractic / Manipulation (Ex: 98940, 98941) Extremity. (98943)? Yes No

\$ Amt / Visit _____ \$ Amt / Yr. _____ / Used _____ Visits/ Yr. _____ / Used _____ Med. Necessity: _____

Physical Therapy (Ex: 97110, 97140, 97014):

(Combined with Chiro?) Yes No Med. Necessity: _____

\$ Amt / Visit _____ \$ Amt / Year _____ / Used _____ Visits Per Year _____ / Used _____

Eval. Management / Office Visit (Ex: 99202):

Coverage percent: _____ % Co-pay amount: \$ _____ Limits? _____ Med. Necessity: _____

X-Rays (Ex: 72040)

Coverage percent _____ % Co-pay amount \$ _____ Limits? _____ Med. Necessity: _____

Diagnostics (95851C, 95851L)

Coverage percent _____ % Co-pay amount \$ _____ Limits? _____ Med. Necessity: _____

Verified by: _____

Date: _____ Time: _____

Pre-existing condition policy? Yes No (If so, what is the waiting period?) _____

Medical Necessity Information? _____

Pre-certification prior to treatment? Yes No Authorization# / Confirmation #? _____

Pre-Certification ph# or fax#: (_____) _____ Name of Rep: _____ Num. of Visits authorized: _____

Pre-Certification notes: _____

Plan Administrator: _____

Send Claim to:

Address: _____

City, State, Zip: _____

Follow-up Ph#: (_____) _____

Electronic Billing? Yes No Payor ID#: _____ Name of Rep: _____

Patient Name: _____