

INSURANCE COVERAGE

FOR PATIENT USE ONLY: Please Provide a Copy of Your Insurance Card to the Front Desk

Patient: _____ Primary (Maybe Parent or Spouse) Insured: _____

Primary Insured's Employer: _____ Insured SS#/ID #: _____

Patient DOB: _____ Insured DOB: _____ Spouse DOB: _____

Group #: _____ Policy #: _____ Effective Date: _____

Patient's Chief Complaint/Diagnosis: _____

Primary Insured (Parent or Spouses) Address:

Name: _____

Address: _____

City, State, Zip: _____ Phone: _____

FOR DC HEALTH CENTER USE ONLY:

Deductible: _____ Family Deductible: _____ Carryover: _____

Deductible Met: _____ Annual out of pocket max: _____

Co-pay: _____ Out of pocket met? _____ Maximum lifetime?: _____

In-Network % covered: _____ Out of Network % covered: _____

Is there a pre-existing condition clause? YES / NO When does it expire?: _____

Insurance Address: _____ Phone: _____

City: _____ State: _____ Zip: _____

Chiropractic Manipulative Treatment Covered (98940, 98941, 98942, 98943) PT/Modalities Covered

Visits per Year: _____

\$\$ Amt limit per Year: _____

Visits per Condition: _____

\$\$ Amt. limit per Condition: _____

\$\$ Amt limit per visit: _____

Office Visit (IOV/ OV Code) If any: _____

X-Ray Covered: _____

Is Outside Lab Work Covered (83520): _____

Date of Verification: _____

Rep. Name: _____

Time of Call: _____

Verified by (Name of Staff): _____

Date of Financial Consult: _____

I understand the quoted benefits and obligations concerning my insurance coverage of chiropractic treatments. I understand that benefits quoted do not guarantee payment.

Patient Signature: _____