VanNess

Chiropractic • Massage • Rehabilitation

CHIROPRACTIC INSURANCE VERIFICATION FORM

Please fill in only the highlighted areas:

Patient Name: ______________________________Date of Birth: ____________ SS#:______________

Name of Insured: __________________________Date of Birth: ____________ SS#: ______________

Insurance Carrier ____________________________ Policy # ____________________________________

Effective Date of Policy______________________ In or Out of Network______________________

Phone Number: ____________________________Group:____

Policy Type: ________________________ Confirmation #:____________________________________

Send Claims to: ____

We will call your insurance company and ask the following questions:

- ❑ Name of person verifying benefits: ___________________________Date ________________
- ❑ What is the co-pay?___________________ Office_________ Manipulation______________
- ❑ Is there a dollar or number of visit limits? ____________________Used?_______________
- ❑ What is the deductible? _____________ Deductible been met? _______________________
- ❑ Family Deductible? __________________ Apply to individual ded? ___________________
- ❑ Life Time Maximum? ___________________________ OPX __________________________
- ❑ Plan year_________________ or Calendar year__________
- ❑ What percentage will the policy cover?

  100% 90/10 80/20 75/25 Other _________________________
- ❑ Is a pre-cert required for services? ___________________ Phone #_____________________

- ❑ Does the policy cover X-Rays? ______________ Percentage Covered ________________
- ❑ Will they cover cervical, lumbar pillows or ice packs? ______
- ❑ Can chiro perform PT? _______ Does it count as a chiro visit or separate? _______
- ❑ Physical Therapy? ______ Limit: ___________/year # of visits ________________

  Insurance percentage? _____________ Authorization Required? _________________
- ❑ Myofascial Release Therapy (97140)? ___________
- ❑ Custom Foot Orthotics? ______ Deductible or Co Pay for orthotics? _____________
- ❑ What percentage does insurance cover? ________
- ❑ Can Chiropractor prescribe orthotics? ___________________
- ❑ Is a letter of medical necessity required? ________________
- ❑ Is precert required? ________________
- ❑ Is there a limit on # of pairs or dollar amount per year? _______________
- ❑ Timely Filing Limit ____
- ❑ ____

  ____

I authorize VanNess Chiropractic to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such chiropractic care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to VanNess Chiropractic. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

I UNDERSTAND AND AGREE THAT ALL SERVICES RENDERED ARE CHARGED DIRECTLY TO ME, AND THAT I AM PERSONALLY RESPONSIBLE FOR PAYMENT. IN THE EVENT COLLECTION EFFORTS BECOME NECESSARY, I AGREE TO PAY ALL COLLECTION COSTS, UP TO 40% REASONABLE ATTORNEY FEES, AND COURT COSTS. I ALSO AGREE TO PAY INTEREST AFTER 30 DAYS AT 5% MONTHLY ON ANY UNPAID AMOUNTS.

If you have any questions or problems, please direct them to the insurance manager.

The above statements and answers are true ____

Patient’s signature Date