Patient Information

Name: _____
DOB: _____
Ins Company: _____
Subscriber ID: _____
Group #: _____

Insured's Information

Name: _____
DOB: _____
Employer: _____
Plan name: _____

Primary/
Secondary Carrier: _____

Date of call: _____ Name of Ins. Representative: _____
Effective date: _____ Renewal date: calendar yr/fiscal yr/group plan yr _____
Chiropractic coverage? Yes/No Max # of yrly visits: _____
Max Allowed Per Year: _____
Co-pay Amount: _____ Deductible Amount: _____
Deductible Amount Met: Yes/No
Deductible Amount Not met: $ _____ Out of Pocket Max: $ _____ % Covered _____
Secondary Ins. Auto Crossover: Yes/No 4th Qtr Carryover: Yes/No Amount: _____
Pre-existing Clause: Yes/No If yes, what is pre-existing condition? _____
Referral or Pre-Authorization Required? Yes/No

Always verify if services are covered IF performed by a chiropractor?

	Covered Service	Subject To Deductible	After Deductible Pays
Maintenance/Supportive Care:			
Spinal Adjustment:			
Manual therapy when performed with spinal manipulation:			
Extra spinal manipulation:			
Examination:			
X-Ray:			
Physical Therapy:			
Massage:			
DME/Orthotics:			
Other:			
Other:			
Other:			

If covered, do physical/occupational therapies apply toward chiropractic visit max? Yes/ No

Always request reference number from insurance representative: Ref#:_____

Retain a copy of this form in the patient's healthcare record.