Insurance Benefits Verification Form

This form is to be utilized by patients in order to inform themselves of the extent of coverage for chiropractic services. It is important that each question is asked and answered to completion by the insurance representative with whom you speak. Remember that verification of benefits is not a guarantee of payment for services and the ultimate responsibility of payment lies with the patient them self.

Jenkins family chiropractic

Practice Member's Name (printed):

_____

Date of Birth:_____ Today's Date: _____

Please have the following information when calling the insurance company:

1. Insurance company's phone number (on the back of your card):_____
2. Policy holders name (if different from practice member's):_____
3. Policy holders Date of Birth: _____
4. Policy holder's Address: _____Phone Number:_____
5. Member ID#_____
6. Group # (if applicable to your policy):_____

1. Person you Spoke with:_____
2. "Out of network" benefits are: _____
3. "In network" benefits are: _____
4. Do you need a referral? _____If yes, from whom? _____Phone # _____
5. What is the yearly deductible: Per Person: _____ Per Family: _____
6. How much of the deductible has been met this year: _____
7. What is the co-pay or co-insurance: _____
8. Is there a limit to the number of visits or $ amount?: _____
   If yes, how many visits are allowed and/or what is the $ limit?: _____
9. Are services limited by "Medical Necessity"?_____
10. Do they cover Wellness or Maintenance Care?_____
11. What is the effective date of the policy: _____
12. Are X-rays Covered?: _____
13. Reference # for this call: _____

Notes:_____

_____

_____