

# Insurance Verification Form

Patient's Name: \_\_\_\_\_

Insurance Name: \_\_\_\_\_ phone: \_\_\_\_\_

Insured's Name: \_\_\_\_\_ date of birth: \_\_\_\_\_

Policy # \_\_\_\_\_ Group \_\_\_\_\_

Insured's Employer \_\_\_\_\_

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Do not write below this line

Does this policy cover Chiropractic? \_\_\_\_\_ in network \_\_\_\_\_ out of network \_\_\_\_\_

Effective date of policy \_\_\_\_\_ Pre-existing clause? \_\_\_\_\_

Is there a deductible? YES/NO family \_\_\_\_\_ individual \_\_\_\_\_ cal yr or fiscal yr?

At what percentage is treatment covered? \_\_\_\_\_ coinsurance \_\_\_\_\_ copay \_\_\_\_\_

Are Xrays covered? \_\_\_\_\_ modalities? \_\_\_\_\_ # per visit \_\_\_\_\_ office visit codes? \_\_\_\_\_ (99201)

Is there a visit limit? \_\_\_\_\_ how many \_\_\_\_\_ \$\$ paid out \_\_\_\_\_

Is physical therapy covered? \_\_\_\_\_ If yes, how many visits? \_\_\_\_\_ Is that combined with the chiro visits? \_\_\_\_\_

Is a referral needed? \_\_\_\_\_ precert? \_\_\_\_\_ if yes, phone# \_\_\_\_\_

Do you accept assignment? \_\_\_\_\_

Where should I send claims? \_\_\_\_\_

Are the following covered? 97012 \_\_\_ 97014 \_\_\_ 97140-59 \_\_\_ 97124 \_\_\_ 97112 \_\_\_ L3020 \_\_\_

Is durable medical equipment covered in the same benefit? \_\_\_\_\_

Name of person to whom you spoke \_\_\_\_\_ date \_\_\_\_\_

Your name: \_\_\_\_\_

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I authorize **Barnes Wellness Center** to call my insurance company and verify the benefits I have available to me under my current insurance plan. I hereby instruct and direct the payment of all professional or medical expense benefits allowable and otherwise payable to me under my current insurance policy to **Barnes Wellness Center** as payment for professional services rendered. THIS IS A DIRECT ASSIGNMENT OF BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above mentioned assignee, and I have agreed to pay in a current manner, any balance of said professional service charges over and above this insurance payment. A photocopy of this assignment shall be considered as effective and valid as the original. I also authorize the release of any information pertinent to my case to any insurance company, adjuster or attorney involved in the case.

Printed Name of Patient \_\_\_\_\_

Signature of Patient \_\_\_\_\_

Date: \_\_\_\_\_