INSURANCE VERIFICATION
Please return verification to our office on next visit

**Spoke with:_____ Date:_____

I am calling to verify eligibility for chiropractic benefits

Patient Name:_____ Date of Birth:__/___/_____

Insurance Company:_____

Address to send claims:_____
_____

Insurance Company phone#:_____

Policy Holder name:_____

Policy Number#:_____Group #:_____

Employer:_____

Effective Date of Policy:_____

Does policy cover chiropractic care: □ Yes □ No

Deductible:
Is there a deductible: □ Yes □ No. If yes, how much?_____

Has the deductible been met? □ Yes □ No. If not, how much is met?_____

Does deductible start January 1? □ Yes □ No:_____

Does policy cover x-rays? □ Yes □ No. What amount?_____

Are x-rays subject to the deductible?□ Yes □ No

Limitations:
What are the copayments for manipulation(adjustments)?_____

Are there any maximums? □ Yes □ No. If yes, what are they?_____
_____

Has maximum for chiropractic care been met for this year? □ Yes □ No.
If yes, how much has been met?_____