S A M P L E

INSURANCE VERIFICATION

TAX ID: _____ PROVIDER: _____ VERIFIED BY: _____
PTAN: _____ DATE: _____ PRIMARY INS? Y/N
DOC NPI: _____ TIME: _____ SECONDARY INS? Y/N
OFFICE NPI: _____

INSURANCE COMPANY: _____ PHONE #: _____

PATIENT NAME: _____SSN: _____ DOB: _____ RELATIONSHIP:_____

INSURED NAME: _____ SSN: _____ DOB: _____

INSURANCE ID: _____ POLICY/GROUP#:_____ EFFECTIVE DATE: _____

IN NETWORK:

Deductible: $_____ Amt met: $ _____
Out of Pocket $_____ Amt Met: $_____
Family Deduc $_____ Amt Met: $_____
Fam Out of Pocket $ _____ Amt Met: $ _____
Co-Ins (after deductible met): % _____
Does out of pocket include deductible? Y/N

OUT OF NETWORK:

Deductible: $_____ Amt met: $ _____
Out of Pocket $_____ Amt Met: $_____
Family Deduc $_____ Amt Met: $_____
Fam Out of Pocket $ _____ Amt Met: $ _____
Co-Ins (after deductible met): % _____
Does out of pocket include deductible? Y/N

Is benefit cycle based on calendar or anniversary year? _____ From: _____ To: _____

4th Quarter Carryover? Y/N Flex Spending Account? Y/N HSA? Y/N

OFFICE VISITS

COPAY: $_____
COVERAGE % _____
Subject to deductible? Y/N

CHIROPRACTIC

Covered? Y/N
COPAY (specialist) $ _____
COVERAGE % _____
Number of visits? _____
Prior Auth required? Y/N

XRAYS

Covered? Y/N
COVERAGE % _____

PHYSICAL THERAPY

Number of visits? _____ Prior Auth required? Y/N

97110 Therapeutic Exercises: Y/N 97140 Manual Therapy: Y/N 97530 Theraputic Activities: Y/N
97014 Electric Stim: Y/N 97012 Mechanical Traction: Y/N 97112 Neuromuscular Re-ed: Y/N

Is preauthorization required prior to treatment? Y/N If yes, phone # to call? _____
Is there a pre-existing condition policy? Y/N If yes, from when to when? _____
Area of body it pertains to? _____
Any other waivers of exclusions on this policy that would restrict coverage? Y/N
If so, what? _____