Insurance Company Worksheet

Patient:

Insurance Company:___________________________

Name of Insurance Co: ___________________ Address of Ins. Co. ________________

Phone #: ____________________ ________________

Group #: ____________________ Effective Date: ___/_____/_____

Call to verify insurance coverage:

1. Does policy include benefits for chiropractic care?: Yes/No
2. What is the deductible?: _____________________
3. Does it cover the office visit? Modalities? What%?: _____________________
4. If there is a maximum allowance, what is it on manipulation or therapies?: _________
5. Exceptions and limitations?: __________________
6. Percentage of coverage after deductible: ___________________
7. Are special forms required?: Yes/No
8. What is the coverage on X-rays and exams?: _____________________
9. Where are claims to be submitted?: _________________

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10. Are dependents covered?: Yes/No
11. Are orthopedic appliances covered?: Yes/No
12. Name of person giving information: _________________