POWELL CHIROPRACTIC PATIENT INSURANCE VERIFICATION

For your convenience, our office is set up to utilize direct payment from insurance companies. However, it is important that you understand that health and accident insurance policies are an arrangement between **you and your insurance company**. For your benefit, please call and verify your chiropractic insurance coverage. **YOU ARE PERSONALLY RESPONSIBLE FOR ALL SERVICE CHARGES INCURRED IN OUR OFFICE.**

STEP 1: Please fill out this form and return it to our **office at or before your next visit**.
Follow the step-by-step directions below to know what your chiropractic benefits include:

Your Name/Patient Name: _____ **DOB:** _____/_____/_____
If spouse/family member carries the insurance plan complete the following:
Insured/Spouse's Name_____ **DOB:** _____/_____/_____
Relationship to Insured: _____ **Patient's SSN:** ____-____-____

List your **Primary Care Provider (PCP)/Family Physician:** _____
Phone number: _____

Insurance Company:_____ **Insurance Phone Number:** _____

*(Locate **Member Services toll-free number** (or website for some plans) listed on the back of your insurance card)*

STEP 2: Call the Insurance company and follow instructions for "Patient"
Say: "I am calling to verify my Chiropractic benefits." Ask the following questions:

Member ID Number: _____ **Group #** _____
Name of the person providing the information:_____ Reference # _____
-Does my insurance policy cover chiropractic: **YES / NO**
-Is Dr. James Powell, Dr. Walter Null, or Dr. Abbey Crouse at **Powell Chiropractic Clinic** a provider with my insurance plan? **YES / NO**
-What is the effective date of my policy: _____/_____/_____
-Does my policy start in January ? **YES / NO** If no, when does it start? _____
Is this a calendar year policy? **YES / NO** or Is this a benefit year policy? **YES / NO**
-Does my plan require timely filing: **YES / NO** What is the time period/months:_____
-What is my deductible? _____ What has been met? _____
-Do I need a referral from my Primary Care Physician? **YES / NO**
-Do I need authorization or pre-authorization from my insurance company to be seen? **YES / NO**
-Do I have a **CO-PAY** due at each visit? **YES / NO** HOW MUCH? $_____.00
-Does **CO-INSURANCE** apply to my plan? If so, what will it be? _____%
(Example of co-insurance may be 80/20 or 70/30, etc)
-How many **adjustment/manipulation** visits to my chiropractor are covered? **#_____visits covered.**
If no number is specified, do I have unlimited visits? **YES / NO**
-How many "97XXX" modalities/physical therapy sessions (i.e. electric muscle stimulation, rehab, exercises) are covered? **#_____visits covered**
-Are there any **limitations** (i.e. specific modality or #/ visit? **YES / NO** Limitations?_____
If no number is specified do I have **unlimited visits**? **YES / NO** _____
If NOT managed by number of visits is my coverage determined by a set dollar amount for the calendar or benefit year? $_____.00
-Are **orthotics** covered under my plan? **YES / NO** Do they need to be pre-certified? **YES / NO**
-Do I need **pre-certification** for any additional testing should my chiropractor order one? **YES / NO**
-What if tests are **NOT** done in the office, i.e. MRI or CT scan: **YES / NO**
-**PRE-CERTIFICATION PHONE** number to call is: Area code (_____) - _____ - _____.

STEP 3: Sign Below and Return to Powell Chiropractic Clinic at (or before) your next visit

Patient Signature _____ **Date:** _____/_____/_____

Powell Chiropractic USE ONLY: File #:_____ **Dr:**_____ **Reviewed by:**_____