QUESTIONS TO ASK YOUR INSURANCE COMPANY REGARDING YOUR CHIROPRACTIC COVERAGE

To verify your insurance coverage, contact your insurance company and ask the following specific questions. Be sure to get the name of the person you are speaking with and note the time and date of your conversation.

NOTE: We are not a member of any insurance networks and do not do precertifications

This process of verifying your coverage will help you determine what YOUR insurance company will reimburse YOU for your care in our office.
(Regardless of your coverage we have other payment options that can help your care be affordable for you).

Insurance coverage was verified on__________________ at_____________am / pm
(today's date) (time)

Speaking with____________________________________
(person's First and Last name)

Name of Insured______________________________ Name of Patient________________________________

Relationship to Patient_________________________ Patient date of birth ____________________________

Insured's Employer___________________________ Insured's date of birth ___________________________

Policy #___________________________________ Group #___________________________________

Insurance Company____________________________ Phone # ____________________________________

Address where claims are sent ____
____ Attn: ____

Please Inform Your Insurance Company that Dr. Mariano is a NON-PARTICIPATING PROVIDER

Does MY policy cover Chiropractic adjustments? Yes_____ No_____

If yes: What percent is covered?___________

What is that percent based on (Ex: Actual Charges or what is considered reasonable)?_________________

Is there a limit to the number of visits allowed ? Yes_____ No_____

If yes: What are those limits?_________________ Are they based on diagnosis?___________

Does that include visits that go toward the deductible?________________

Is it based on the calendar year or another date?________________

What is the deductible? $___________ Has it been met? _____ If not, how much is left? $_______________

Is the deductible per person_____ or per family_____? Effective date of policy ________________________

Which of the following are covered:?

Physical Exam	Yes___	No___	_____%	Surface EMG	Yes___	No___	_____%
X-rays	Yes___	No___	_____%	Vitamin supplements	Yes___	No___	_____%
Homeopathic remedies	Yes___	No___	_____%	Orthotics	Yes___	No___	_____%
Supports/braces	Yes___	No___	_____%	Low Level Laser	Yes___	No___	_____%

Your Phone Number ________________________ Your E-mail Address_________________________________

Regardless of your coverage, we have other payment options that can help care be affordable for you and your family