Optimal Care
14205 Park Center Dr.
Suite 207
Laurel MD 20707
Phone (301)-362-5868 Fax (301)-362-5869

Insurance Verification Form

We encourage all patients to verify their insurance benefits prior to their first visit to fully understand their policy and treatment coverage. Please call the customer service number on the back of your insurance card.

Name: _____ DOB: ____/___/_____

Policy Holder's Name: _____ DOB: ____/___/_____

Primary Insurance: _____ ID#: _____

Secondary Insurance (**For Medicare patients only**): _____ ID#: _____

Please ask the following questions:

Effective date of the policy: ____/___/_____

Is my provider covered/part of my network? [ ] Yes [ ] No – Ask the next question.

Is there an out of network benefit? [ ] Yes [ ] No

Details: _____

Is there a deductible for my policy? [ ] Yes-Ask next question [ ] No

Amount of deductible: _____ Amount of deductible met: _____

Is the deductible based on a fiscal or a calendar year? [ ] Fiscal [ ] Calendar

If based on a fiscal year: _____ to _____

Does the deductible apply to chiropractic benefits? [ ] Yes [ ] No

How many chiropractic treatments may I receive? _____ How many have been used? _____

How many adjunctive therapy treatments may I receive? _____ How many have been used? _____

What is my co-payment amount? _____ Or what is my co-insurance amount? _____

Are these commonly recommended treatments covered with my plan?

Procedure	**Procedure Code**		
New Patient Examination	99202-99204	[ ] Yes	[ ] No
Established Patient Examination	99212-99214	[ ] Yes	[ ] No
Spinal Manipulation	98940-98941	[ ] Yes	[ ] No
Extremity Manipulation	98943	[ ] Yes	[ ] No
Muscle Stimulation	97014/G0283	[ ] Yes	[ ] No
Therapeutic Exercise	97110	[ ] Yes	[ ] No
Manual Therapy	97140	[ ] Yes	[ ] No
Massage	97124	[ ] Yes	[ ] No
Activities of Daily Living	97535	[ ] Yes	[ ] No
Orthotic Evaluation	97760	[ ] Yes	[ ] No
X-Ray Analysis	72010	[ ] Yes	[ ] No

Is durable medical equipment covered (L3020)? [ ] Yes [ ] No Details: _____

Is pre-certification needed for any other treatment procedures? [ ] Yes [ ] No

Pre-certification point of contact: Phone: _____ On what services: _____

Reference # for your call: _____ Date of call: ____/___/_____

Please fax to us OR bring the completed form with you for your first scheduled appointment.