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	99201-99203	[ ] Yes	[ ] No
Established Patient Examination	99211-99213	[ ] 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
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 on your first scheduled appointment.