Allied Chiropractic, P.A.

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Insurance Verification Form

We **highly encourage** all patients to verify their insurance benefits prior to fully understand their policy & treatment coverage. Your insurance policy is between you and your insurance company. Please call the customer service number on the back of your insurance card.

Patient Name: _____ DOB: ____/___/_____

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

Primary Insurance: _____ ID#: _____

Secondary Insurance: _____ID#: _____

Name of insurance customer service representative: _____

Employee ID # (if available): _____

Reference # for your call:_____

Date of call: ____/___/_____ Time of call: _____ AM/PM

Ask the following questions:

1.) Effective date of the policy: ____/___/_____

2.) Is my provider covered/part of my network? [ ] Yes [ ] No
Is there an out-of-network benefit? [ ] Yes [ ] No

Details: _____

3.) Is there a deductible for my policy? [ ] Yes [ ] No → **Go to Question #4**

Amount of deductible: $_____ Amount of deductible met: $_____

Amount owed by me once deductible is met? [ ] none [ ] 80%/20% Other: _____

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

If based on a fiscal year : _____ *to* _____

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

4.) Do I have a co-pay or co-insurance amount? [ ] Co-pay [ ] Co-insurance

If yes, *what is my co-pay or co-insurance amount? $*_____

5.) Is there a maximum number of visits per policy year? [ ] Yes [ ] No → **Go to Question #6**

If yes, *how many visits have been used as of today?* _____

What is my max? _____

Are physical therapy & Chiropractic visits bundled? [ ] Yes [ ] No

6.) Is a referral needed to visit a Chiropractic Physician? [ ] Yes [ ] No

7.) Are the following services **covered and/or payable** with my insurance plan if performed by a Chiropractic Physician?

Procedure	**Procedure Code (CPT)**		
New Patient Examination	99202-99203	[ ] Yes	[ ] No
Established Patient Examination	99212-99213	[ ] Yes	[ ] No
Spinal Manipulation	98940-98941	[ ] Yes	[ ] No
Extremity Manipulation	98943	[ ] Yes	[ ] No
Electric Muscle Stimulation (EMS)	97014/G0283	[ ] Yes	[ ] No
Therapeutic Exercise	97110	[ ] Yes	[ ] No
Manual Therapy	97140	[ ] Yes	[ ] No
Dry Needling	20561	[ ] Yes	[ ] No
Kinesiotaping		[ ] Yes	[ ] No

Additional Notes (ex: one exam covered per year):_____

8.) Is the following imaging **covered & payable** if ordered by a Chiropractic Physician?

Type		
X-rays	[ ] Yes	[ ] No
MRI	[ ] Yes	[ ] No
CT Scan	[ ] Yes	[ ] No

Is a pre-certification required for <u>any</u> imaging? [ ] Yes [ ] No

If yes, who is the pre-certification point of contact:

Name/Company: _____

Phone: _____

9.) Is Chiropractic care **<u>covered and payable</u>** if it is **<u>not medically necessary</u>**? [ ] Yes [ ] No

10.) Is pre-certification needed for any other treatment procedures if performed by a Chiropractic Physician? [ ] Yes [ ] No

If Yes, on what services: _____

If you complete this, please email back to: AlliedStaff@AlliedChiropractic.com <u>or</u> bring completed form with you to your next scheduled appointment.